

**FINAL REPORT OF FIGO WORKSHOP  
IN SANTIAGO 4 -5 NOVEMBER 2010**

**FIGO - ADOLESCENT SEXUAL AND  
REPRODUCTIVE HEALTH (ASRH)**

**17 MAY 2011**

**APPROVED BY FIGO LONDON**

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## **Antecedents.-**

The FIGO informed to president of FIGIJ about the Project developed on Sexual and Reproductive Health for Adolescents , mainly in the the area of services for them. This document should be adaptated to differents Regions of the World. For that purpose FIGO was supporting Regional Workshops around the World , with Experts. The final objective is to have an adaptation of the original document for different Regions.

For Latinamerica this task was asked to the President of FIGIJ and Expert in this matter in the Region . It was decided to develop the Workshops in Santiago of Chile on the first trimester of 2010.

The organization of the meeting, determination of participants was under the responsibility of the expert and FIGO and the administrative and financial support was the responsibility of FIGO. An important contribution for the printed and row material was received from Silesia, a national phamaceutical Industry in Chile.

The meeting was programmed for 11 and 12 of March 2010. But on 27 of February it was an earthquake in Chile, (One of the biggest five in the last 50 years, world wide). It was impossible to perform the meeting. It was decided by FIGO and local Chairman to delete the meeting until the end of 2010.

Finally the meeting was developed on 4 and 5 november in Santiago.

## **Objectives.-**

- 1.- To develop a regional consultation with Experts on Adolescent Sexual & Reproductive Health and Services. (ASRHS) for adaptation of FIGO Report on Adolescent Sexual and Reproductive Health Services.
- 2.- To analyze the report elaborated by FIGO on ASRHS.
- 3.- To adapt this information to the Latinamerica reality in those more important subjects regarding with Education , Reproductive Health, Personnel Training on ASRH and strategies to prevent adolescents pregnancy and STI and Aid's.
- 4.- To propose a written additional statement to the original report of FIGO.

## **Method.-**

### **Instruments.-**

A.- Original FIGO Report .- It was translated to Spanish language and reviewed.

B.- 36 questions were designed from the six chapters of the FIGO Report for adults participants. From these 36 question, 21 were asigned to adolescents participants (See Annex 1 and 2)

C.- The questionnaire were sent to all participants: 16 adults and 8 adolescents, from 7 countries, 2 adult participants from each country (Argentina, Brasil, Chile, Colombia, México, Panamá and Uruguay). From Chile was 4 adults and 2 adolescents participants.

D.- All the participants answered the questionnaires. The answered were counted and the results expressed in Tables inserted in the original Spanish report version for discusión at the Workshops.

E.- This document was the main instrument for two days of discusión divided in six chapters.(See Annex 3)

F.- The group discussion was recorded and transfered to a written document ( 94 pages), for analysis of the participant interventions.

G.- The summarized discussion was sent to all participants and they send back the changes and comments included in the last version.

G.- The discussion document already summarized and reviewed by the participants was, tranlated to English and inserted at side of each accounting results of the questionnaire and original questions .

F.- Each of the question with results and the summarized discussion was inserted in the original English draft version.

### **Selection of Experts.-**

A.- **Adults** participants were selected by the coordinator who knows the main academic people and directors of the Adolescents and Paediatrics Gynecological Societies of the Latinamerican Region. It were included some Experts from the Ministries of Health.

B.- **Adolescents** were nominated by the adult Experts of each country.

### **Results.-**



**Options Alliance South Africa**

## **FIGO - ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (ASRH)**

**DRAFT FINAL REPORT**

**Rachel Grellier  
Paula Quigley  
Louise Hulton**

**March 2009**

### **LATINAMERICAN WORKSHOP TO ADAPT THE DOCUMENT TO REGION**

**DRAFT FINAL REPORT  
Latinamerican Team  
Coordinator Prof. Dr. Ramiro Molina C**

**March 2011**



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Amanda Lee of FIGO provided important background information which helped to put the study into context; and Sinead Rowan and Katharine Boaden of Options UK provided administrative support in initiating and concluding the study.

Finally, we would like to thank all FIGO members: without their contribution this study would not have been possible. They very generously gave their time to participating in the survey and interviews, and for that we are most grateful.



## ACRONYMS

AFC	Adolescent Friendly Clinics
ASRH	Adolescent Sexual and Reproductive Health
CEPDA	Centre for Population and Development Activities
CMAT	Commonwealth Medical Association Trust
COPE	Client Oriented Provider Efficient
CPD	Continuing Professional Development
DHS	Demographic and Health Surveys
FHI	Family Health International
FIGO	International Federation of Gynecology and Obstetrics
FPA	Family Planning Associations
FSUM	Swedish Society for Youth Centres
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
MDG	Millennium Development Goal
MICS	Multi-Indicator Cluster Surveys
NGO	Non-Governmental Organisation
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
YFS	Youth Friendly Services

## EXECUTIVE SUMMARY

Adolescent sexual and reproductive health (ASRH) forms a major component of the global burden of sexual ill-health but has historically been overlooked in terms of sexual and reproductive health interventions. International agencies are now, however, increasingly focusing on improving ASRH and providing programmatic funding.

The International Federation of Gynaecology and Obstetrics (FIGO) has obtained funding from UNFPA to strengthen the capacity of FIGO country offices to support ASRH interventions at national level. In order to determine how FIGO can effectively contribute to improving ASRH, Options undertook:

- A literature review of adolescents' (10 – 19 years) attitudes; perceptions of health professionals; and programmes already assessed for effectiveness.
- A survey of obstetricians' and gynaecologists' attitudes, knowledge and perceptions of ASRH.
- A critical review of existing tools and guidelines for ASRH services, and professional training and education.

### Literature Review

Adolescents' health and well-being is intrinsically linked to their social, cultural and economic environment. In all regions adolescents are reaching puberty earlier and marrying later so they are sexually mature for longer before marriage. Differences between groups of adolescents e.g. urban/rural, in-school/out-of-school, girls/boys influence access to health care and sources of education, information and support. The main risk factors affecting adolescents' health outcomes are: early sexual initiation, substance abuse, depression, ignorance about contraception.

Evidence shows that there are key principles and actions for effective interventions:

- There is no 'fixed menu' suitable for every country.
- Assessments of local stakeholder and institutional capacity are important.
- Age-appropriate approaches are essential.
- Abstinence only programmes have not been shown to be effective. More effective is a life-skills approach.
- Sex education programmes should build skills for negotiating sexual behaviours.
- Peer education and outreach can be combined with non-peer education methods
- Youth-friendly services (YFS) can be effective if designed well.
- Health care providers are often unable and unwilling to adopt an effective and sensitive manner with adolescents.
- Adolescents need access to quality YFS & technically competent, non-judgemental health care providers trained how to work with adolescents.
- Monitoring and evaluation should be included from the start.
- Girls and boys need equal access to youth development programmes.
- Scaling up should be planned from the start.

Policy issues need to be promoted at country level. These include:

- Advocating for laws protecting adolescents from sexual exploitation.
- Working with government to enforce laws on age of marriage.
- Where abortion is legal, promote greater accessibility for adolescents. Where abortion is restricted, facilitate provision of family planning and post-abortion care
- Support enforcement of laws against female genital mutilation/cutting.

- Explicitly address gender and other inequities.
- Ensure very young adolescents are also targeted in ASRH programmes.
- Advocate for keeping adolescents in school as long as possible.
- Support the development of youth leadership
- Programmes should involve parents, community leaders and youth
- Campaign for comprehensive, life skills-based SRH education

### **FIGO members survey and interviews**

The survey and interviews explored members perceptions of national policy, service delivery, professional training and education, and attitudes towards adolescents. Thirty three percent of FIGO members participated in the survey and/or interviews.

Eighty percent of respondents reported that national policy explicitly addressed ASRH but in many of these countries rights were restricted by either gender or marital status. Fewer respondents said that these rights were translated into equal access to ASRH services. ASRH programmes were frequently structured in such a way that boys were excluded, while girls often found it difficult to access government provided services due to restrictions on mobility and health workers negative attitudes.

- What does work well:
  - Specialist services e.g. YFS & family planning associations.
  - Specialist staff e.g. peer educators, psychiatrists, physicians.
- What does not work well:
  - Specific aspects of care e.g. abortion services, access to contraception.
  - School-based sex education programmes.
  - Government run health facilities.
  - Multi-disciplinary and collaborative working was seldom practiced.

ASRH is an explicit part of training for obstetricians & gynaecologists in 37% of countries and there was strong demand (90%) for FIGO to become involved in developing training modules. FIGO could add value to new or existing tools by investing resources in national associations to adapt them to regional contexts. Development and promotion of tools also needs to be matched with large-scale, well targeted, skilfully facilitated training workshops. Training modules should include social aspects of health; and have a clear focus on male and female adolescents' needs.

Nineteen out of twenty two interviewees said ASRH is a critical issue for FIGO due to:

- Global levels of mortality and morbidity among adolescents
- The impact adolescent health/ill-health has on health in later life
- Intrinsic links between ASRH and FIGO's existing priorities

Adolescent girls' powerlessness and vulnerability was seen to be a key issue as prejudice exists within government, social & cultural institutions, communities, and individuals. This impacts on girls ability to access health care and as a result many programmes focus on increasing girls access to health services and information. An unintended consequence of this is leaving boys unable to access services specifically designed for adolescents. There is a need to redress the imbalance.

Health professionals and parents often have negative/ judgemental attitudes towards giving adolescents sexual and reproductive health information. This is frequently due to

anxiety about the impact of this information on sexual behaviour. There is no evidence for this, but many believe that lack of knowledge is an effective deterrent.

### **Review of tools and guidelines**

The review focused on tools and guidelines developed by internationally respected organisations and which can be adapted for different country contexts. A specific focus of the review was consideration of whether FIGO can add greatest value through the development of new tools or by adapting and endorsing existing tools.

A framework summarising different categories of tools was developed. This covers:

- Orientation guidelines
- Provider training curricula
- Support & counselling (including post-emergency and disaster situations)
- Programme planning
- Peer education
- Specific tools (married youth, community involvement, youth participation)

Three resources (produced by WHO, Pathfinder and Engender Health) were identified as tying in most closely with information requested by participants. All three are holistic in their coverage of clinical and social aspects of ASRH; tested and validated; are available free of charge in a variety of formats i.e. on-line, CD-Rom, hard copy. It is recommended that FIGO review these three and identify one resource to take forward for accreditation by a specialist association e.g. FIGO, RCOG. This would increase credibility and enable training to contribute to continuing professional development (CPD). FIGO could then fund small regional working groups to adapt the tool for specific regions, followed by funding widespread training workshops at national level.

### **Conclusion**

As a global professional organisation with extensive country level presence and a high degree of technical competence, FIGO can play an important role in improving ASRH. This is what FIGO's members would like it to do. It is important to consider how FIGO as an organisation can add greatest value to current activities in ASRH, and this is most likely to be through building on its existing institutional strengths and expertise, particularly in pre- and in-service training; and international advocacy, development of policy briefs and position statements at international level to support national efforts. FIGO could also optimise the effectiveness of its involvement in ASRH by development/membership of coalitions, partnering with organisations experienced in programme implementation and management; and participating in multi-disciplinary/multi-sectoral working groups.

There are also areas in which FIGO has less experience but potentially could help fill significant gaps at national level. These include:

- Contributing to national/local situation analysis.
- Advocacy for legislation/improved implementation.
- Policy development
- Technical guidance to ASRH initiatives.
- Quality assurance – contribute to quality control of interventions.
- Monitoring of effectiveness - extending FIGO's professional competence.
- Scaling up – providing support through extensive connections and reputation.

## 1. INTRODUCTION

The International Federation of Gynaecology and Obstetrics (FIGO) brings together national societies of obstetricians and gynaecologists from 113 high-, middle- and low-income countries and territories, and is committed to strengthening women's health, rights, and access to reproductive health services. FIGO has a strong professional reputation for its work to improve gynaecology and obstetrics practice, particularly through provision of education and training.

FIGO is also committed to contributing to international development benchmarks such as the Millennium Development Goals (MDG) and to improving the health status of poor and under-served women. Until now FIGO has not explicitly focused on the sexual and reproductive health of adolescents, although they have been considered within broader programmes, for example Prevention & Treatment of Fistula.

Adolescent sexual and reproductive health (ASRH) has been overlooked for many years as a major component of the global burden of sexual ill-health. However, international agencies such as the United Nations Population Fund (UNFPA) and World Health Organisation (WHO) as well as international and national non-governmental organizations (NGO) are now focusing on improving ASRH and on providing programmatic funding for interventions.

FIGO is currently strengthening its partnerships with other international professional organisations including UN agencies and has obtained funding from UNFPA to strengthen the capacity of FIGO country offices to support ASRH interventions at national level. This complements FIGO's wider objective of strengthening its capacity to support national societies and, alongside this, increasing national societies' capacity to play a major role in advocacy, training, policy development and reproductive health programmes.

In order to determine how FIGO can effectively contribute to improving ASRH, avoid duplication of efforts, and identify potential partners from whom lessons can be learned, FIGO commissioned Options Consultancy (Options) to carry out a preliminary study of affiliate associations' views on ASRH. The findings are reported here, alongside a review of existing literature on young people's attitudes, perceptions of health professionals working in the field of sexual and reproductive health (SRH), and programmes which have already been assessed for effectiveness. Finally, this report also contains a critical review of existing tools and guidelines for ASRH services and recommendations are made regarding how they can be taken forward for use or adaptation by FIGO.

## QUESTION N° 1 What Include ASRH?

Question N°1	Written Answers from participants	SUMMARY OF GROUP DISCUSSION
<b>QUESTION N° 1</b>		
<b>What Include ASRH?</b>	<b>YES NO</b>	Dr. Matilde Maddaleno, in representation of PAHO/WHO informed of the new trends and regional proposals for 2015, which are aimed at lowering <b>Maternal Mortality, and in which ASRH</b> plays an important role. She informs of an open tender for Successful ASRH Initiatives.
*Prenatal Care	16	
*Posnatal Care	16	
*New Born/suckling child Care	12 4	The 7 countries agree with <b>most</b> of the components described for ASRH services. The differences arise from <b>different models or systems</b> of healthcare organisation. An example of this is the Programme for Infants that attends to newborn babies and infants. In other cases, negative responses stem from legal constraints, as is the case of the use of Misotrol, which is restricted to the hospital. It is related with abortion depenalisation restrictions in the Region. Nonetheless, there is a parallel market in which consumption is not controlled by the Health System. The case of Uruguay is described, in which the law that depenalises pre abortion counselling and its resulting fall in complications caused by illegal abortions. Many countries (Mexico, Brazil and others) made suggestions recommending legal abortions in special cases: maternal risk and sexual abuse.
*Contracept. Repeat. Pregn.Prevent.	16	
*Contraception. 1 <sup>st</sup> Pregn. Prevent.	13 3	
*Counselling on abortion	13 3	
*Misoprostol prescription	9 7	
*Postabortion Care	13 3	
*Counselling on Adoption	10 6	<b>Adoption counselling</b> is carried out as an isolated action, but is not part of the programmes. It is a new element. The same happens with <b>Family Counselling</b> , which is not offered routinely, but is given in specific cases detected by the Social Services. Rules regarding <b>Sexual Abuse and Harassment</b> were found to lack in strength.
*Adoption procedures	11 5	
*STD Prevention	16	
* STD diagn & Treatment	14 2	
*Pediatric & Adolesc Gynecology	15 1	
*Male Care	13 3	
*Sexuality Counselling	13 3	
* Gender Counselling &Homosexual.	13 3	It included <b>ASRH care in chronic pathologies and in disabled adolescents</b> that make up an increasing volume of higher fertility risk subjects. Brazil has solid experience in these cases, and many publications on the subject. These are included in the bibliographical references.
* Transexualism	13 3	
*Counselling on sexual Harassment	14 2	
*Sexual Abuse	14 2	Various countries added concepts that are part of comprehensive ASRH care, rather than direct activities or actions and many of the suggestions are part of the Social Workers' Counselling and Detection tasks. Issues like <b>Violence and Drug Control</b> are two realities that must be faced and that are detected during ASRH attention and should be addressed according to the organisation of the health or social protection Systems of each country; this must always be done in coordination with the ASRH services, where they are detected.
* Mental Health support	13 3	
* Social Work Support	13 3	
* Family Counselling	10 6	
Violence	Social Work	
Chronic Diseases	Total Inclusion	
Drugs Care	Special Social Work	
Sexual & Reproductive Right	Included in Counselling	In short, ASRH components are varied and each country should adapt them to its own existing Health System.

QUESTION N° 1	Written Answers from participants	SUMMARY OF GROUP DISCUSSION
<b>QUESTION N° 1</b>		
<b>What Include ASRH?</b>	<b>YES NO</b>	Dr. Matilde Maddaleno, in representation of PAHO/WHO informed of the new trends and regional proposals for 2015, which are aimed at lowering <b>Maternal Mortality, and in which ASRH</b> plays an important role. She informs of an open tender for Successful ASRH Initiatives.
*Prenatal Care	16	
*Posnatal Care	16	
		The 7 countries agree with <b>most</b> of the components

## **2. METHODS**

### **2.1 KNOWLEDGE, ATTITUDES AND PRACTICE SURVEY AND INTERVIEWS**

A letter introducing the study was sent by email to all 113 country associations by FIGO in December 2008. The survey was sent out by email in January 2009 and hard copies were sent by fax or post when email contact was not possible. Two follow-up requests for surveys to be returned were sent out during February.

Sixty nine country members were also randomly selected by FIGO to be invited to take part in a telephone interview. Interviews were held in English, French and German and explored in more detail key issues concerning current ASRH policy, rights and access. Interviewees were also asked how important they felt it was for FIGO to become involved in ASRH, and why.

The total number of countries participating in this study (combining surveys returned with the telephone interviews) is 37 (33%). This number is too low to allow the data to be analysed by region, however the overall similarity of responses indicates that the data do provide meaningful insight into broad areas of concern for FIGO members, and useful information on their perceptions of how FIGO as an international federation can best support national and international efforts to improve ASRH.

### **2.2 LITERATURE AND TOOLS/GUIDELINES REVIEW**

The reviews focus on recent information (from the year 2000 onwards) and present a concise but strategic overview of key issues in ASRH and evidence informed practice drawn from a wide range of sources. An extensive annotated list of reference material is provided, along with links to online sources and a list of useful websites for those wishing to explore specific issues in more detail.

A wide range of tools and guidelines exist which have been shown to be effective. These include training modules for health practitioners; guidelines for integrating ASRH into health practitioner pre- and in-service training curricula; and resources for increasing meaningful youth participation in programming at institutional and programmatic levels. Where evidence is lacking, however, is on how particular programmes can effectively be scaled-up. This is a gap that is widely acknowledged, as is the need for it to be filled.

An annotated bibliography of a broad range of tools and guidelines is also attached to this report for readers who wish to obtain further information on appropriate tools for specific initiatives and settings, including conflict and post-conflict areas.

**Question N<sup>o</sup> 2 What is your experience to increase in effective way some specific programs on ASRH?**

<p><b>QUESTION N<sup>o</sup> 2</b></p> <p>What is your experience to increase in effective way some specific programs on ASRH?</p>	<p>Training specific manpower: 3</p> <p>Increasing the difusión of Services : 2</p> <p>Increasing Services for Adolescents:7</p> <p>To train comprehensive teams : 2</p> <p>No answer :2</p>	<p>Experience shows the positive aspects of comprehensive care, taken as ASRH attention involving multiprofessional staff and varied components. The participation of adolescents as promoters and peer consultants is described as positive, for the adolescents and adults participating in the scheme, which includes permanent professional advice. Chile described that this strategy is not part of its adolescent care model. Uruguay has had various positive and negative experiences with adolescents as promoters of ASRH. It has been difficult to assess the results of these strategies. The experience of Colombia was described, in that country the community was grateful when friendly services were made available to adolescents. Argentina described its experience of articulating and creating networks of friendly services with in out patient primary and secondary attention units in Hospitals. Another positive strategy has been the use of confidential hot lines to give adolescents counselling and advice.</p>
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### **3. LITERATURE REVIEW**

Terms used in the literature include adolescents (10-19 years), youth (15-24 years) and young people (10-24 years). Our review focuses on adolescents while acknowledging that many publications may refer to either a broader or more specific group.

Adolescents' health and well-being is intrinsically linked to the social, cultural and economic environment within which they live. As a result international agencies such as UNFPA place considerable emphasis on the need to position the adolescent and youth agenda within a broad development and poverty alleviation context [1]. ASRH, however, is widely recognised as an issue that has historically been neglected, for example none of the MDGs explicitly references youth's reproductive health, even though its relationship to alleviating poverty cannot be overlooked [2]. As a result of this there has been a considerable focus over the last few years on highlighting the importance of improving ASRH and on programmatic funding.

This literature review analyses recent studies on young people's attitudes and perceptions of health professionals working in the field of SRH and examines existing programmes and activities which have already been assessed for effectiveness.

**QUESTION N° 3 In your experience the ASRH services . Should be include adolesc. & Youngs.? ¿10-19/ 15-24/ 10-24? Should Include Men and Women or Women , only?**

<p><b>QUESTION N° 3</b></p> <p>In your experience the ASRH services . Should be include adolesc. &amp; Youngs.? ¿10-19/ 15-24/ 10-24?</p> <p>Should Include Men and Women or Women , only?</p>	<p>Include 10 a 24 : 12</p> <p>Include 10 a 19 : 4</p> <p>Include Women &amp; Men : 16</p> <p><b>Adolescents:</b></p> <p>The 8 participants adolescent answered from 10 to 24 years old and Men and Women</p>	<p>Different inclusion criteria were proposed. But this will depend on the existence of solid child care programmes and their coverage, including paediatric care in the area of ARSH and specially trained nurses. This is especially applicable in children of <b>14 years of age or less</b>, who are legally considered to be potential abuse victims in the case of contraceptive use, as is the case in Argentina, Chile and Colombia. In Mexico this group consults relatively infrequently on ASRH related issues. The subject of <b>School Health Integrated to the Education System</b> rises strongly. It provides ongoing attention in a <b>Continuum of Life</b> that is applied to Health Care and especially to ASRH. This will permit the integrated transfer of Sex Education from the Education to the Health System. Girls in the <b>19 to 24</b> year age group are considered adults in many of the participating countries and their attention will depend on the capacity and availability of regular adult SRH services. The group recommends an adaptation of existing health networks.</p> <p>Participant adolescents said that they thought that providing care from the ages of 10 to 24 should not be a problem when ASRH services are required and that there should be no gender discrimination in this area.</p>
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### 3.1 WHAT DO WE KNOW ABOUT ADOLESCENTS?: SOME FACTS AND FIGURES

In every region of the world young people are reaching puberty earlier and marrying later [3]. As a result young people are generally sexually mature for a longer period before marriage. Although the sexual experience of youth varies across regions, evidence shows that within regions there are relatively high levels of consistency in a number of key aspects of ASRH [4]. However, it is important to understand that despite the broad consistencies, there are also vital differences within and between different groups of adolescents, which strongly influences their access to health care, sources of education, information and support available to them. Some of the key ASRH issues, particularly those most relevant to FIGO members, are further explored:

#### QUESTION N<sup>o</sup> 4 Have you had experience to know access differences for adolescents to ASRH services? Explain please.

<p><b>QUESTION N<sup>o</sup> 4</b></p> <p>¿Have you had experience to know access differences for adolescents to ASRH services? Explain please.</p>	<p>Influence of service providers : 8</p> <p>Low level of Privacy : 3</p> <p>It is related with Cultural aspects:4</p> <p><b>Adolescents</b> : Yes : 7</p> <p style="padding-left: 40px;">NO : 1</p> <p>From those with answer Yes, they comments exist lack of Information : 3</p> <p>Health Care for Women ,only : 2</p>	<p>In general, adolescents do not consult spontaneously. A strategy would be to integrate it with education through School Medicine or School Health schemes. They ask about already installed problems. A change in strategy is essential. The proposal is that ASRH problems should not be solved by experts.</p> <p>Female and male adolescents said that what was most important was communication on the part of the care givers. Difficult access to services is made easier with a more adequate attitude on the part of health professionals. Privacy and confidentiality are indispensable.</p>
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#### 3.1.1 Information, education and support

The main risk factors in young people that affect their health outcomes are early sexual initiation, substance abuse, depression and ignorance about contraception [5]. However, providing information, education and support to adolescents in order to minimise these risks involves firstly understanding the diversity of youth with regards to such aspects as their age, gender, marital status, schooling status, living arrangements and migration status [6]. The most effective interventions enhance the factors that protect adolescents from harm and diminish their risk of having a negative health outcome [5]. Important protective factors identified by the WHO and others include the following [5,6,7,8]:

- **Education and schooling** – staying in school is highly protective and should be a priority for all countries, especially concerning girls to avoid early pregnancies and poor maternal and neonatal outcomes.

**QUESTION N° 5 Do you know model where School potency the ASRH? Explain the model**

<p><b>QUESTION N° 5</b></p> <p>Do you know model where School potency the ASRH? Explain the model</p>	<p>Scarce / Not evaluated : 7</p> <p>It has been usefull : 5</p> <p>Only speech in School : 4</p> <p><b>Adolescents</b></p> <p>YES : 4</p> <p>NO : 4</p>	<p>Experiences are very limited. Nonetheless Panama, Colombia and Mexico have shown that when ASRH care is combined with or merges with community activities this makes the Health Centre more attractive for adolescents. Colombia is developing a National Commission in which Sexual and Reproductive Rights involve the Health, Education, Communications, Labour sectors and the Colombian Institute of Family Welfare.</p> <p>Adolescents with sexual experience mentioned the education and lectures given at school.</p> <p>They also said that they had seen different attitudes in health givers after they had received training on the subject.</p> <p><b>Dr. Maddeleno</b> must withdraw to return to PAHO and informs of the <b>Longitudinal Concept of the Life Course</b> and its impact on attention, instead of separated programmes divided into transversal compartments. There is a tardy impact if programmes are started in adolescence, and especially with vulnerable children who will become vulnerable adolescents. If for example, School Health includes home visits, it would be possible to detect and prevent repeated pregnancies. To this we must add that the financing of attention systems for determined ages makes attention schemes and models more expensive. It is indispensable for this to adapt to existing resources. On the other hand, it is indispensable to design differentiated interventions according to vulnerability levels, because not all adolescents present the same risks. This systemic and longitudinal vision would be more promising in order to achieve the targets of the coming decade.</p>
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*A WHO review of adolescent help-seeking behaviour [29] found that trust is a huge factor for adolescents; informal support is a significant source of information as well as formal health services; and involving adolescents themselves in research activities to better understand youth is essential. This calls for integrated approaches addressing multiple needs of adolescents.*

- **Families and communities** – good relations with parents and community members make an enormous difference to the well-being of adolescents. Programmes involving families and communities are more likely to be successful.
- **Beliefs and values** – individual faith can be an important factor for adolescents in generating responsible attitudes. Furthermore, societal openness about youth sexuality facilitates pragmatism as shown in the differences between some European countries and the US, where Europe generally has a more liberal approach [9]

**QUESTION N° 6 What is your experience to involve minor of age in research actions? ¿ How do you resolve the approval of Ethical Committee?**

<p><b>QuestionN° 6</b></p> <p>What is your experience to involve minor of age in reserch actions?</p> <p>¿ How do you resolve the approval of Ethical Committee?</p>	<p>Informed Consent: 9</p> <p>Without experience: 5</p> <p>It is nor allowed in the country: 1</p> <p>No answer :1</p>	<p>A difference is established between Informed Consent for adults and for minors (most of whom are under 18 years of age.) Informed Assent for the clinical attention of a minor is different from that required for a clinical or social/epidemiological study, which require anonymous responses. In these last cases, in Chile, the corresponding Ethics Committee accepted Informed Assent for a National Study. Argentina has the legal status of minor young adult of 14 years of age and under 18 years of age that can exercise her/his civil rights. In Brazil, the age for Minor Adults is over 12 years; the Ethics Committees require parental consent. In Colombia, the depenalisation of abortion has established that even when an adolescent is under 14 years of age, if she is emotionally and intellectually mature, she has rights over her health and reproduction.</p> <p>This information is extremely pertinent for demography and health surveys that for legal reasons include subjects of over 15 years of age. This is a problem that has not been solved. Each country still has to analyse the reality of Informed Consents and Assents for adolescents of between 10 and 18 years of age, the latter being the age of majority in most countries. This is confidentially applied in adolescent medical consultations, respecting their autonomy, privacy and confidentiality</p>
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<p><b>Teen Pregnancy Rate in US</b></p>	<p>5 times that of Netherlands 4 times Germany</p>
<p><b>Teen Birth Rate in US</b></p>	<p>9 times that of Netherlands 4 times Germany</p>
<p><b>Teen Abortion Rate in US</b></p>	<p>Twice that of Germany Nearly twice Netherlands</p>

**QUESTION N° 7 There is a lack of information in the Region. It is included at the end. If you have information of your country or local experience , It will be useful to have it.**

<p><b>Question N° 7</b></p> <p>There is a lack of information in the Region It is included at the end.</p> <p>If you have information of your country or local experience , It will be useful to have it.</p>		<p>We include for revision country submissions for the bibliography which <b>Mexico will prepare in the last item of the Seminar.</b></p>
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However, adolescents face huge barriers in accessing information and services on SRH, [2,3,6,7,8,10,11,12] including:

- **Social or cultural barriers** – accepted early marriage and child-bearing, migration, urbanisation, media, peer pressure
- **Personal barriers** – fear of parents or community knowing, fear of violence, concern about side effects
- **Service related barriers** – cost, location, youth-friendliness, judgemental attitudes, concern about confidentiality, lack of supplies.

*Research indicates that the single most important barrier to care for adolescents relates to providers' attitudes [11]. In many societies and cultures, adults have difficulty accepting teens' sexual development as a natural and positive part of growth and maturation. Lack of confidentiality, embarrassment, and feeling that they are not taken seriously or respected deters youth from using services but not from having sexual intercourse, thereby exposing them to unnecessary risks.*

**QUESTION 8 Have you had experience in the change of attitudes of health providers? Please. Describe the experience**

<p><b>Question N° 8</b></p> <p>Have you had experience in the change of attitudes of health providers? Please. Describe the experience.</p>	<p>Yes : 10</p> <p>No : 3</p> <p>No answer : 3</p>	<p>Fundamentally, it was agreed that the change in attitude of the health providers was related to their levels of training and readiness to work with youngsters.</p> <p>Emphasis was placed on the fact that a great majority of negative attitudes has its root in the fact that health providers have no information regarding the laws of their country and this is an essential item to include in training programmes.</p>
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Successful programmes show that providing information, education and support, as well as other aspects of ASRH, for adolescents is more effective and can help young people practice healthier behaviours when certain principles are respected and applied in the design of interventions [6,7,8,11,12,13,14,15,16,17,18,19,20]. These principles include:

- ✓ Knowing what adolescents are doing and thinking [14]
- ✓ Respecting the diversity of young people [21]
- ✓ Finding out about the attitudes of parents and teachers [22,23]
- ✓ Encouraging youth leadership and building self-confidence [13,14]
- ✓ Using media effectively [15,18]
- ✓ Ensuring meaningful involvement of communities [18,24]
- ✓ Understanding the social environment young people live in [25]
- ✓ Integrating capacity building measures with local stakeholders [26]
- ✓ Having effective systems of synthesising and utilising information [27]
- ✓ Addressing a range of interventions aimed at the broader community as well as adolescents [28]

**QUESTION N° 9 Reorder these principles in relation with your experience. Put the number 1 to 10 at the end of each phrase , regarding the importance of your experience in the assignement of each principle .**

Question N° 9	PRINCIPLES OF ORIGINAL DOCUMENT	ADULT	ADO	
Reorder these principles in relation with your experience. Put the number 1 to 10 at the end of each phrase , regarding the importance of your experience in the assignement of each principle .	Knowing what adolescents are doing and thinking	1 - 2	1 - 2	Knowing what adolescents do and think is the absolute priority for both groups.
	Respecting the diversity of young people	1- 3	5 - 10	The second priority, which is coincidental in both groups, is an understanding of the Social environment in which youngsters live. The second also includes Respect for Diversity in Young People. The last are also coincidental for adults and young people:
	Finding out about the attitudes of parents &Teac	2 - 4	5 - 10	
	Encouraging youth leadeship and building self confidence	3 - 6	1 - 4	*To have effective systems for synthesising and using information and
	Using media effectively	5 - 8	5 - 9	
	Ensuring meaningful involvement of communities	3 - 6	6 - 10	* Address a range of interventions that aim at the whole community and at adolescents.
	Understanding the social enviroment young people live in	1 - 5	1 - 4	
	Integrating capacity building measures with local stakeholders	6 - 8	5 - 10	
	Having effective systems of synthesising and Utilising information	7 - 10	7 - 10	
	Addressing a range of interventions aimed at the broader community as well as adolescents	7 - 10	7 -10	

### 3.1.2 Contraception

As noted above, in many countries adolescents face significant barriers to using contraception, in addition to obtaining SRH information, as is evident from the following statistics [3,4]:

- In sub-Saharan Africa, knowledge about modern contraception is generally lower than other regions but use of contraception by teenage women is low in most countries, except in Europe and the US
- Contraceptive use by sexually active teenage women ranges from only two percent in Niger, Rwanda, and Senegal, to less than 11% throughout Latin America and the Caribbean, and 34% in Indonesia, but rises to 75% in the US, 88% in France, and 92% in Great Britain
- Reported condom use at last higher-risk sex is low in the majority of countries, with female youth being less likely to have used a condom at last higher-risk sex than male youth

Primary abstinence (where the person has never had sex) is more common in South/Southeast Asia and North Africa/West Asia/Europe than in other regions and is more likely to be practiced by young women than young men [4]. Secondary abstinence (where the person has had sex but has not engaged in intercourse in the past 12 months) is practiced by a much smaller proportion of youth and is more common in sub-Saharan Africa than in other regions.

There has been much debate about the effectiveness of abstinence only programmes compared to those that promote contraceptive use. Contrary to common belief, abstinence programmes are not effective at delaying sexual initiation and reducing teen pregnancy [30]. What does seem to be effective in reducing the risk of unwanted pregnancies and sexually transmitted infections is providing accurate, balanced sex education, including information about contraception and condoms.

#### **QUESTION N° 10 Have you experience in SHRA with 1<sup>st</sup> or 2<sup>nd</sup> Abstinence Methods ? Have you experience on Sexual Education Programs?**

<p><b>Question N° 10</b></p> <p>Have you experience in SHRA with 1<sup>st</sup> or 2<sup>nd</sup> Abstinence Methods ?</p>	<p>YES : 4</p> <p>NO: 12</p>	<p>In practice, none of the participants had experience in Sexual Abstinence, and with the experiences in Argentina, Chile, Colombia, Mexico and Panama a recommendation was issued in the sense that it was necessary to emphasise safer sexual practises and although this is a valid option, it is usually limited to religious teaching institutions.</p>
<p>Have you experience on Sexual Education Programs?</p> <p>Describe , please.</p>	<p>YES : 11</p> <p>NO: 5</p>	<p>In terms of sex education, they are considered integral and that they have a gender perspective.</p> <p>Despite the existence of laws for sex education development in every country in the region, the programmes have not been developed or have lacked continuity. The reasons for this are mainly political and religious. A consensus was reached on the absolute need for sex education in educational establishments and in the community.</p>



### 3.1.2 Pregnancy (intended and unintended)

Every year 15 million women aged between 15 to 19 years give birth, 13 million of them in less developed countries [3]. Pregnancy- and childbirth-related complications are the number-one killers of 15-19 year old girls worldwide, accounting for 70,000 deaths every year [31,32,33].

The impact of early pregnancies is not only experienced by the mother but also the child, as infant mortality is highest in countries with the largest proportions of births to adolescents, children born to mothers under the age of 20 are significantly more likely to die than those born to mothers ages

20 to 29, and young adolescents are more likely to experience premature labour, spontaneous abortion, and stillbirths than are older women [2].

Thus, addressing adolescent pregnancy by helping young people avoid unwanted pregnancies, and providing adequate care for those who become pregnant, should be a high priority for governments and can contribute significantly to achieving the MDGs [33].

- \* Teenage pregnancy is more common in Sub-Saharan Africa, Latin America and the Caribbean than in South/Southeast Asia [4]
- \* It is also more common in adolescents who live in a rural area, are less educated, or have limited exposure to the media [4]
- \* Compared to women in their mid-twenties, women under age 15 are at 25 times greater risk of dying from complications related to pregnancy or childbirth, while 15- to 19-year old women are at twice the risk [3]

### QUESTION N° 11 Have you information of Maternal /Perinatal Morbidity,mortality of mothers 10 to 19 years of your country or Region?

<p><b>Question N° 11</b></p> <p>Have you information of Maternal /Perinatal Morbidity,mortality of mothers 10 to 19 years of your country or Region?</p>	<p>The answer is the FLASOG report to be presented at the Workshop, but not performed because the time was not enough. Attached at the end <b>in Spanish</b></p>	<p>At the end of this Document there is an attached PDF text of the Latin American Federation of Obstetrics and Gynaecology (FLASOG) regarding maternal mortality in girls less than 14 years of age.</p>
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**QUESTION N° 12 Have you experience in Special Programmes for Pregnant adolescents and adolescents Mothers and their children?**

<p><b>Question N° 12</b></p> <p>Have you experience in Special Programmes for Pregnant adolescents and adolescents Mothers and their children?</p> <p>Describe the experience.</p>	<p>YES: 4</p> <p>NO : 12</p>	<p>It describes the strategies of preferred care for children of adolescent mothers with an intergenetic interval of two years. The Brazilian experience started in Universities, while in Panama, it was first seen in Primary Health Care Clinics.</p> <p>Another experience in Argentina reports on excellent hospital follow up of adolescent mothers, but of the discontinuation of the programme for lack of funding that prevents completing results.</p> <p>Another experience in Uruguay has been home visits and follow-up, but with no tabulation data.</p> <p>The other experience in Chile was that of a special school with crèche and nursery school for pregnant adolescents and adolescent mothers. Follow-up showed significant effectiveness when compared to adolescent mothers in the regular education system or who have discontinued their schooling.</p> <p>A comment is that another alternative is to give the adolescent father educational support.</p> <p>This indicator would be one of the parameters to assess the impact of the Andean Plan for Adolescent Pregnancy Prevention, developed and supported by the United Nations Population Fund in the region.</p>
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**3.1.4 Abortion**

Adolescent birth rates are intertwined with rates of spontaneous and induced abortion. Worldwide, mostly as a result of unintended pregnancy, nearly four and a half million adolescents undergo abortion each year; around 40% of these occur under unsafe conditions [3]. In countries where abortion is restricted, unsafe abortion can cause up to 30% of maternal mortality [34].

Unsafe abortions vary substantially across regions: 15-19 year olds account for 25% of all unsafe abortions in Africa, whereas the proportion in Asia, Latin America and the Caribbean is much lower [34]. Where abortion is restricted or where adolescents have difficulty in accessing, even if it is legally available, post-abortion care services can provide important support and improve the subsequent use of contraceptives [35].

**QUESTION N° 13 Have you information about complicated abortions hospitalized in women between 10 to 19 yeras old, in your country or Region ? Please send information available.**

<p><b>Question N° 13</b></p> <p>Have you information about complicated abortions hospitalized in women between 10 to 19 yeras old, in your country or Region ? Please send information available.</p>	<p>YES : 3</p> <p>NO :13</p>	<p>Uruguay reported that since the implementation of the Ordinance for Abortion Counselling for at risk conditions and especially in adolescents, the number of abortion-caused deaths fell to 0.</p> <p>Mexico informed that its system included information by quinquennial gropus and that Brazil has made a special study of abortion-caused hosptialisations. Its information is contained in its SUS (Public Health System) system, and can be accessed directly, as is the case of Mexico.</p> <p>Panama reports that its national system, called APAAMEU contains data of all abortion-caused hospital discharges and that it has developed a preferential attention system for post-abortion women with a special concern for giving them contraception indications prior to discharge.</p> <p>Chile said that the current legislation resulted in a considerable under-recording of discharges for complications owing to illegal abortions. It was proposed that FIGO makes technical recomendations on indicators to measure SRH. It was reported that CEPAL and CELADe are generating these indicators.</p> <p>It was concluded that information regarding Adolescent abortions is extremely deficient, although some information can be found in the FLASOG document</p>
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**3.1.5 Access to treatment for sexually transmitted infections (STI)**

Only a minority of adolescents have access to any acceptable and affordable STI services [36]: projects for youth more commonly address counselling and family planning but often fail to include STI care among their service delivery objectives. While availability of valid data on STI rates among young people is limited, it is believed that large proportions of various STIs occur in people less than 25 years [34]. Adolescent girls have higher rates of STIs than boys as they are at higher risk since they often have older partners and they are biologically more vulnerable [3,34,36]. At highest risk are adolescent sex workers, their clients and street children.

*In parts of **sub-Saharan Africa** almost half of girls are pregnant by the age of 19, and adolescent girls make up almost half of those having abortions. The majority of people newly infected with HIV are aged from 15-24 years. Girls are five times more likely than boys of their age to become infected [12].*

Treating STIs is of paramount importance as they greatly facilitate the transmission of HIV

[37]. Provision of services for STI care depends on the context in a particular country and may be provided in schools if incidence is high, or can be integrated into adult STI clinics with appropriate adaptations for adolescents [36].

### 3.1.6 HIV & AIDS

HIV & AIDS is a huge, and growing, threat to young people in every region. At least 95 per cent of all new infections occur in less developed countries. Sub-Saharan Africa is the hardest hit region, followed by the Caribbean while Eastern Europe and central Asia are experiencing some of the fastest growing HIV prevalence rates [37,38].

Young people, aged 15-24 years, represent 45% of all new infections. In order to address this urgent situation it is essential for young people to have the means to protect themselves. However, currently:

- *Young men are better informed* about HIV/STI prevention than young women but they are much more likely to have multiple sexual partnerships and engage in higher-risk sex than young women [4]
- *HIV-testing is rare* among both young men and young women despite high levels of knowledge about HIV & AIDS [4]
- *Young women are more vulnerable* to the HIV epidemic than are men – young women comprise 57% of all young people with HIV, and in the hardest-hit region, sub-Saharan Africa, young women comprise 76% of cases among young people [38]

### QUESTION N° 14\_ Which is the prevention diagnosis and treatment strategy of STD /HIV&AID's in the ASRH Program, where you have experience?

<p><b>Question N° 14</b></p> <p>Which is the prevention diagnosis and treatment strategy of STD /HIV&amp;AID's in the ASRH Program , where you have experience?</p>	<p>The answers show: There are not specific strategies for Adolescents. Its describe the Sexual education and specific Services for Adolescents, as the main tools.</p>	<p>In Mexico, HIV detection is carried out in public places like Metro stations and Universities, but not in schools. Colombia has implemented a detection system in its friendly services for adolescents.</p> <p>It is proposed that every education and services strategy should be part of the Continuum of Life and of School Health care.</p>
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### 3.1.7 Special Circumstances

- ❖ **Married adolescents:** instead of providing a state of security and safety for adolescent girls, early marriage often brings many problems, including removal from school, isolation, risk of HIV and other STIs, and potentially negative health outcomes for mother and child from early pregnancy [6,39]. Early marriage is

particularly common in South Asia, and in parts of West Africa, the Middle East and Latin America.

- ❖ **Conflict:** those adolescents who live in conflict zones are affected by many problems, such as fear of violence, including rape; displacement; lack of respect; inability to continue schooling; risk of STIs, including HIV; lack of access to health care, and lack of skills for finding jobs [40]. Special programmes are required to address the SRH needs of such adolescents, as well as assisting them to become reintegrated into society.
  
- ❖ **Female Genital Cutting:** in countries where the practice is still prevalent across the middle of Africa from Burkina Faso, Mali, and Gambia in the west to Uganda, Tanzania and Kenya in the east, a special programme of accelerated abandonment is underway to help the affected countries take greater action to reduce this harmful practice and its negative consequences 41]

**Question N° 15 Which is your experience on: precocious Wedding , adolescents involved in Guerrillas or warlike conflicts in your country? Are there genital mutilation in your country or sexual practices**

<p><b>Question N° 15</b></p> <p>Included is a table a Table built by the Coordinator.</p> <p>Which is your experience on: precocious Wedding , adolescents involved in Guerrillas or warlike conflicts in your country? Are there genital mutilation in your country or sexual practices with minors of age ?</p>	<p>There is a low frequency of precocious Redding. They are consensual unions and the genital mutilation are described as special situations in te Colombian Guerrilla and also located in the geographycal limit of Panamá with Colombia in the terrotory of Colombian guerrilla.</p> <p><b>Adolescents:</b> Without experience in Precocious wedding and Genital Mutilation . The same comments of adult participants, regarding Colombian guerrilla.</p>	<p>Brazil describes the serious problem of child prostitution, which is associated to sex tourism, especially in the North East of Brazil.</p> <p>Colombia reports on similar problems in tourist areas like Cartagena de Indias, in the coal transportation route and certain highways. They report on a serious problem created by mothers prostituting their daughters.</p> <p>Genital mutilation in Colombia exists on a single Indian reservation and in other isolated events.</p> <p>There are no published data, only press reports.</p>
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### 3.2 KEY PROGRAMMATIC ISSUES

The facts presented above and programmatic experiences reveal some key principles and actions that should be observed in order to provide effective SRH interventions for adolescents:

1. There is no single 'fixed menu' suitable for every country but each country must develop its own **specific package** according to the local economic, epidemiological and social context [14,25,29,37,50]
2. Conduct assessments of local stakeholder and institutional **capacity** for supporting, implementing and evaluating ASRH programmes and **involve** young people, families and communities in designing interventions [12,14,37]

#### Thailand - Friend Corners

In Thailand, the Ministry of Public Health has developed 350 Health Promoting Hospitals, committed to health promotion and to making health services more user-friendly. In 2001, the Department of Health began to introduce Friend Corners outside school and college hours in local shopping malls and community housing areas. The first point of contact is with adolescents trained as peer counsellors. Health staff are also on hand to provide counselling or basic primary care or to refer adolescents to specialised services as necessary. The Friend Corner web site combines music, fashion and health information, and has been praised for making information accessible in an attractive way [12].

#### Question N° 16 Which is the Program menu on ASRH, that you know or mamanged in your country?

<p><b>Question N° 16</b></p> <p>Which is the Program menu on ASRH, taht you know or mamanged in your country?</p>	<p>The answer made a mixture of subject concepts with strategies of the programs</p>	<p>The consensual summary was that there is no fixed or ideal menu for ASRH programmes. Every country adapts to its own reality. What is essential is to consult on the importance of including or not including the components discussed in the first question, in accordance with the resources and experience developed.</p>
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#### Question N° 17 Have you experience on Evaluation in ASRH programs in your country?

<p><b>Question N° 17</b></p> <p>Have you experience on Evaluation in ASRH programs in your country?</p>	<p>YES : 10 NO : 5</p>	<p>Chile reports on two assessments of the Adolescent Health Programme. One which is very critical of the programme objectives and another with qualitative results after 10 years of application. Colombia and Panama mention assessments carried out with different sampling techniques and case histories. They are administered by the Ministries of Health and are internal documents that are not published. Mexico reports on experiences regarding internal and external assessments of the Adolescent Health Programme. Mexico and Colombia state that they will send documents regulating service evaluations.</p>
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3. Ensure **age-appropriate** approaches for different groups of young people, bearing in mind that it is easier to influence behaviour before sexual activity starts [32,51]

**Question N° 18 In your experience, Are there programs on SHRA to different adolescent ages? ,**

**¿Are justified in our Reality**

<b>Question N° 18</b>	YES : 2	<b>Adolescents</b> YES: 2	In general, the group believed that at the development stage of the programmes it would be inefficient to develop specific programmes according to age and that this is not justified in the current reality.
In your experience, Are there programs on SHRA to different adolescent ages? ,	NO: 14	NO: 5	
	YES : 9	<b>Adolescents:</b> YES:4	
¿Are justified in our Reality?	No : 7	NO: 3	

4. Abstinence only programmes have not been shown to be effective: a better method is to combine abstinence messages with clear communication on the importance of reduction in number of partners, condom use, and dual protection to prevent HIV/AIDS/STIs and pregnancy: this is best achieved through a **life-skills approach**. Sex education programmes should offer accurate, comprehensive information while building skills for negotiating sexual behaviours [7,16,18,19,30,32,37,42,50,51,53]
5. **Peer education and outreach** are effective methods and can be combined with non-peer education methods [16,18,19]

**Question N° 19 Have you experience on ASRH programs with peers , in your country? what's has been the results?**

<b>Question N° 19</b>	YES : 9	Argentina, Chile, Panama and Mexico promise to send in documents. On discussing the issue, it is detected that research into the area is scarce. Adolescents say that they are the products of a monitor training system. Although their participation and existence is acknowledged, emphasis is placed on the fact that published information is essential for disseminating knowledge and experiences.
Have you experience on ASRH programs with peers , in your country?	NO : 7	
	YES : 9	
what's has been the results?	NO : 7	



6. **Essential components** of ASRH programmes include information and counselling, access to STI/HIV treatment and care, contraception provision, and maternal health services [12,32,37,50,56,57]

7. Adolescent- or **Youth-friendly health services** have been shown to be effective when certain characteristics are present: they need to be located in suitable places where they can be easily reached but not too obvious, they should be free of cost or very affordable, they should be attractive to youth with a warm, informal atmosphere, they should guarantee privacy and confidentiality, and they should have a sufficient range of services and supplies to meet the multiple needs of that particular youth population [11,12,14,15,19,37,42,47,50,56,57]

**Costa Rica**

has a strong programme for adolescents based on a solid political, legislative and social structure [14]. Key success factors & results include:

- ✓ This is a comprehensive service covering the whole country
- ✓ There is broad political commitment to the needs of adolescents
- ✓ A national training programme is being implemented for health workers
- ✓ Young people receive training to provide leadership on health.

**Question N° 20 Are there experiences of Friendly Services in your country? Please, describe the friendly strategies**

<b>Question N° 20</b>	YES :15 <b>Adolescents:</b> YES:2	Practically all the questions, responses and discussions of adult and adolescent participants have been base done the national experiences of friendly services with different organisations, structures and experiences.
Are there experiences of Friendly Services in your country? Please, describe the friendly strategies	NO : 1 NO: 5	
	<b>FRIENDLY :</b> The attitude of Medical doctor, only	

8. Situation analyses and needs assessment exercises carried out in different parts of the world point to shortcomings in the professional capabilities of **health care**

**South Africa (NAFCI)**

*The National Adolescent Friendly Clinic Initiative (NAFCI) uses a certification and assessment system to help improve the quality of health services to youth at public clinics. It was envisioned as a national program from the outset. After an 18-month pilot period, moving from single districts to larger areas, NAFCI had the participation of 350 clinics with 171 associated clinics by late 2005. The program, which is part of the larger LoveLife Program addressing young people’s sexual health through multiple approaches, is implemented through the Department of Health. The departmental link helps ensure sustainability. Passage of positive youth health policies helped to facilitate the launch. A majority of the clinics that have been externally assessed (212) complied with 80 to 90 percent of the NAFCI standards for youth-friendly clinics. The NAFCI success has been linked with strong leadership at all levels, political support, collaboration with stakeholders, youth and community involvement, and provision of technical support [58]*

**providers** working with adolescents and in their 'human qualities' as a result of which they are unable and oftentimes unwilling to deal with adolescents in an



effective and sensitive manner. All adolescents need access to quality youth-friendly services provided by clinicians proficient in working with this population: health care providers catering to adolescent populations need to be specially trained on how to work with youth, they must be non-judgement in their interactions, sensitive to youth's needs and technically competent [11,12,15,47,49,56,57]

**QUESTION N° 21 Have you experience in the Health providers on ASRH? Which has been the teaching methologies used for? Is there continuos training? Is there Long Distance Training, On line system?**

<p><b>Question N° 21</b></p>	<p>YES : 14</p>	<p>In Argentina, there are monthly meetings with formats that vary in time. Chile believes that training should be short so as not to overload the services and increase costs; the ideal would be On line training.</p>
<p>Have you experience in the Health providers on ASRH?</p>	<p>NO : 1 No Answer: 1</p>	<p>In Panama, ongoing education for professionals is part of the required accreditation.</p>
<p>¿ Which has been the teaching methologies used for?</p>	<p>Theoretical and Presencial teaching:14 Not described:2</p>	<p>All participating countries consensually agreed that training must be ample and unbiased by ideological approaches. Argentina believes that staff training should involve Universities, ONGs and Scientific Societies, which must be coordinated by the respective ministries; this opinion is shared by the majority. Nonetheless, the Ministries of Education do not participate and there is insufficient legislation on the subject. It is believed that IFEPAG endorsements are not acknowledged by the countries, with only a few exceptions. In part this is caused by the fact that the speciality of PAG (Paediatric and Adolescent gynaecology) is not recognised, and that this activity is limited to programmes and to ASRH. This is related to the fact that FIGO does not recognise FIGIJ (International Federation of Child and Adolescent Gynaecology) and to the lack of ARSH subjects in Undergraduate Health Courses. The recognition of the related specialities does not solve the problem, but does contribute to improve training levels in primary care.</p>
<p>¿ Is there continuos training?</p>	<p>YES: 3 NO: 13</p>	<p>The regional and international options for the recognition of PAG were analysed. The scenario is preoccupying because the greater difficulties reside in the Associations of Specialists in Adults.</p>
<p>¿Is there Long Distance Training, On line system?</p>	<p>YES: 5 NO :11</p>	<p>Nonetheless, training strategies should include all the health careers involved in ASRH. Brazil and other countries officially recognise Adolescent Medicine, but not PAG. But, the solution would not lie with specialists, but with primary care, with the training of undifferentiated professionals. Another suggestion was the importance of Regional Federations such as FLASOG and ALOGIA to coordinate staff training with International Agencies like PAHO and UNFPA. The group also consensually agreed that On Line distance training has a basic cost that must be covered, because technologies are expensive. An ample and in-depth discussion on On Line Ongoing Education ensued. <b>In the discussion, Dr. Hamid Rushwan, Representative of FIGO said that he would relay a message regarding the recognition of the PAG Speciality with an ARSH context to FIGO headquarters.</b></p>

9. **Monitoring and evaluation** methods should be developed from the start of the programme, rather than as an afterthought, and where possible using a randomised comparative methodology to measure effectiveness and outcomes of programmes [6,16,17]
10. Girls and boys also need equal access to youth development programmes that connect them with supportive adults and with educational and economic opportunities. ASRH programmes can be complemented with **additional supportive measures** in the community, with the media, and with local institutions; and **scaling up** of successful initiatives should be planned from the start with adequate attention to costing, documentation, involvement of a wide range of committed partners, and confirmed support from government [14,15,18,25,32,42,45,58]

**Question N<sup>o</sup> 22 Have you experience in ASRH coordination and others activities in community?**

**Question N<sup>o</sup> 23 In your experience on ASRH Services Are they working in network to resolve problems with different level of complexity and diversity?**

<p><b>Question N<sup>o</sup> 22</b></p> <p>Have you experience in ASRH coordination and others activities in community?</p>	<p>YES: 10</p> <p>NO : 6</p>	<p>The discussion and exchange focused on the coordination of programmes or services for attending to adolescents through regular paediatrics services and others. There was a consensual agreement that adolescence starts at the age of 10 and that this space should be maintained in adolescent healthcare services. The application of the principle of comprehensive ongoing attention and the implementation of school health was discussed again, owing to its relevance.</p>
<p><b>Question N<sup>o</sup> 23</b></p> <p>In your experience on ASRH Services Are they working in network to resolve problems with different level of complexity and diversity?</p>	<p>YES with success: 5</p> <p>YES with failures: 6</p> <p>NOT working : 5</p>	<p>Coordination networks operate partially and their management and operation requires much closer coordination. This is part of a health policy and organisation of the systems.</p>

### 3.3 KEY POLICY ISSUES

A number of important policy issues arise from the evidence presented above and from the experiences of programmes. These need to be promoted at country level and include:

- 1) Advocate for laws that protect adolescents from **sexual exploitation**, particularly focusing on the most vulnerable groups, including street children, adolescent sex workers, migrants, refugees, and victims of violence [1,5,6,20,25,40,44,46,54]
- 2) Work with government to enforce laws on age of **marriage**, and where early marriage is prevalent, work with health care providers, parents and communities to encourage delaying of the first pregnancy [2,6,20,33,39]
- 3) Where **abortion** is legal, promote greater accessibility for adolescents combined with post-abortion counselling and access to contraception, and where abortion is illegal or restricted, facilitate the provision of comprehensive family planning programmes and post-abortion care [32,35]
- 4) Support the enforcement of laws against **female genital mutilation/cutting** where the practice is prevalent [20,27,41]
- 5) Address **gender and other inequities** explicitly and advocate against the restriction of ASRH programmes to any section of the youth population [1,6,7,20,21,25,31,32,33,35,39,40,41,44,46,54]
- 6) Ensure that **very young adolescents** (10-14 years) are also targeted in ASRH programmes so that they can be reached with appropriate information before becoming sexually active [1,21,32,51]
- 7) Advocate and support measures for keeping adolescents **in school** as long as possible, including following pregnancy for girls [5,6,16,32,33,43,45]
- 8) Support the development of **youth leadership** [14,18,37,42,45,55,56]
- 9) Design programmes that encourage **active participation** of parents, community leaders and youth [6,11,12,16,22,23,24,28,29,37,55]
- 10) Campaign for comprehensive, life skills-based **SRH education** in schools and communities [6,19,27,30,37,42,43,50,51,52,53,61]
- 11) Design **multi-sectoral, integrated programmes** that address multiple youth needs [6,14,18,25,27,30,37,44,45,49,54,60,61]
- 12) Facilitate greater accessibility by adolescents to **SRH services and supplies** by strengthening health systems [11,12,32,34,47,49,50,56,57]
- 13) Encourage greater involvement of the **private sector**, especially for social franchising schemes, voucher systems, and social marketing to increase access to services and supplies [19,47,49,58]
- 14) Establish mechanisms for **scaling up** of successful interventions with government support and keep expansion in mind when designing new programmes [16,17,37,49,58,59]

- 15) Ensure **vulnerable groups** are included in national ASRH policies where relevant, for example, refugees, street children, married adolescents, victims of violence, orphans, drug users, adolescent sex workers [1,21,25,27,33,44,]
- 16) Recognise that health care workers cannot meet all the needs of adolescents alone and should **join or create networks** that act together and maximise resources [12,18,34,37,42,44,58,59,60]

#### **4. FIGO MEMBERS' KNOWLEDGE, ATTITUDES AND PRACTICE**

The survey and interviews focused on four key issues related to ASRH: policy, service delivery, professional training and education, and social and cultural issues. Respondents discussed the situation in their own country, the role of their national association and the broader role of FIGO as an international federation. The views expressed were those of individuals, albeit individuals who were nominated representatives of national associations of obstetricians and gynaecologists. Seventy three percent of respondents were male and 87% (n=26) regularly treat adolescents as part of their clinical practice. The average number of adolescents attended to each month was 65, ranging from 3 to 700.

The small sample size in this study renders a regional breakdown of results by region inappropriate, as this would wrongly imply that the data are representative. However, the striking similarity of responses both within regions and overall do enable us to infer that the views expressed are representative of a broad consensus of professional opinion.

Where responses clearly acknowledged regional, cultural or religious impact on attitudes, policy or practice, these are reported.

##### **4.1 POLICY ISSUES**

###### **4.1.1 National policy**

Eighty percent of respondents reported that national policy did in some way address ASRH. The majority of policies explicitly supported adolescents' right to confidentiality (96%, n=24), and a smaller, but still substantial, majority supported adolescents' rights to access contraception (79%, n=19) and to access services (as long as they were over the age of legal sexual intercourse) without parental or, in the case of young women, their husband's consent (71%, n=17).

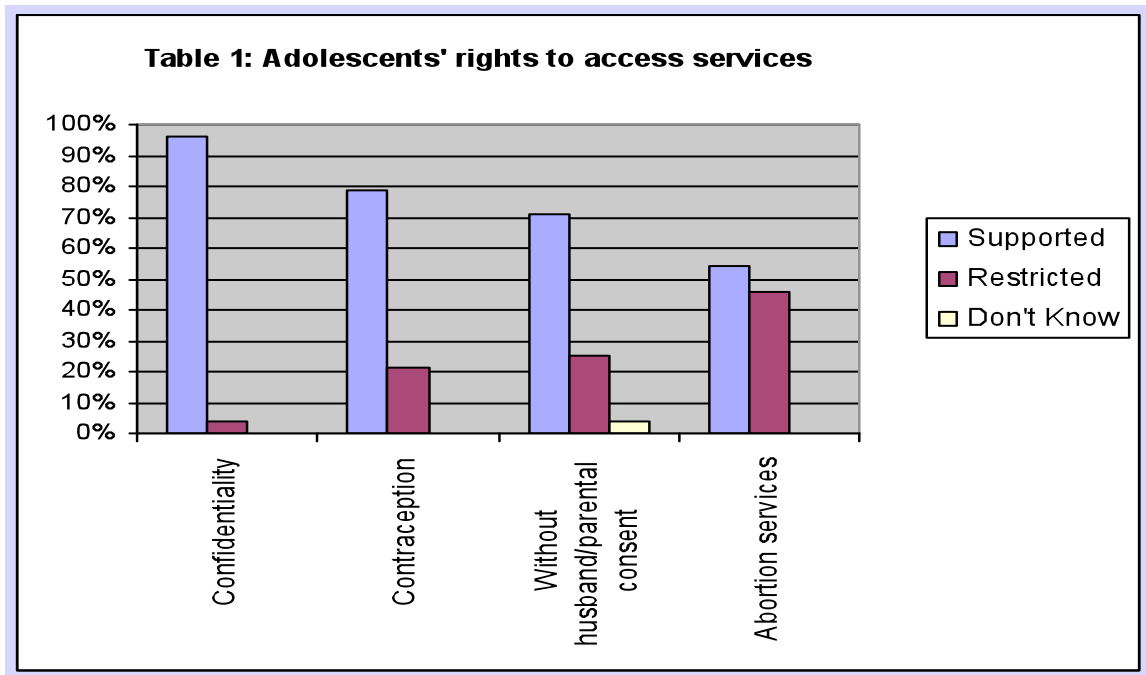
Not surprisingly, far fewer national policies provide adolescents with the right to access abortion services (54%, n=13). This is more a reflection of national legislation banning abortion for the entire population than a disparity between the rights of adolescents and adults.

Respondents were also asked whether national policy which addressed ASRH explicitly restricted adolescents’ right to access any of these services. Forty six percent of policies restricted adolescents’ right to abortion services (n=11), 25% (n=6) constrained their right to access services without parental/husband’s consent, and 21% (n=5) limited adolescents’ rights to access contraception (table 1).

**QUESTION N°24 On your experience , Is it possible to have ASRH services without a National Policy about?**

<p><b>Question N° 24</b></p> <p>On your experience , Is it possible to have ASRH services without a National Policy about?</p>	<p>YES : 1</p> <p>NO :15</p> <p><b>Adolescents:</b> NO: 5</p> <p>With doubts : 2</p>	<p>The discussion was very short. The only response was that if there is a belief in the possibility of development without national support, this would pertain to the private sector. A strategy is clearly a national policy.</p>
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Western Europe was the only region (Denmark, Iceland, Italy, Spain, Sweden, UK<sup>1</sup>) where all responses to each question described an actively supportive national policy for adolescents over the age of legal sexual intercourse



<sup>1</sup> With the exception of Northern Ireland.

**Question N° 25 In relation with your experience, Which are the main barriers for development of ASRH Services? AND , ¿What has been the main important factors in their failures?**

<p><b>Question N° 25</b></p> <p>In relation with your experience, Which are the main barriers for development of ASRH Services? AND</p> <p>¿What has been the main important factors in their failures?</p>	<ul style="list-style-type: none"> <li>*Lack of de Personnel Training</li> <li>*Lack of Public Policies</li> <li>*Lack of economical support</li> <li>*Strong Political influence of the AntiRights Groups on Sexual &amp; Reproductives Adolescent Rights:</li> <li>*Lack on ASRH services information:11</li> <li>*Lack of Sexual Education : 3</li> <li>*Lack of a National Policy : 5</li> </ul>	<p>There was consensual agreement on the subject, and especially on the influence of ultra conservative groups in the region.</p> <p>Lack of investment in Programmes for Adolescence and Youth is notorious in the region.</p>
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The survey also explored whether adolescents' **rights** to services vary by gender or by marital status. Eighty two percent (n=24) of respondents reported that, in theory, male and female adolescents have equal rights to SRH services, 10% (n=3) reported that they do not, while two respondents (7%) were unsure. Inequity slightly increased by marital status, with 78% (n=23) of respondents reporting that married and unmarried adolescents have equal rights to services, while six respondents (20%) reported that they do not. The Middle East and North Africa region showed greatest discrimination against female and unmarried adolescents, largely to due religious laws relating to sexual intercourse, and was the only region in which all those who responded to these questions reported differential rights.

*"Our society is closely working with, let's say, the Ministry of Social Affairs on the different policies. We are working in advocating different sectors of sexual health related matters and giving opinion papers, and we are collaborating with these key people, like at political level and ministerial level. Our organisation and our experts have been involved - like working out different policies". (Estonia)*

*"... because of big introductory work that has been done with many international NGOs and government, and we had a special multi-disciplinary group who worked on that (ASRH policy). Er, no, I shouldn't tell that it was very easy, of course, but at the same time not too difficult". (Georgia)*

*"The organisation is very much involved in the consultatory role for maternity care. As far as adolescent health is concerned for this policy I think they have been invited ... for most of these activities"*

### 4.1.2 Advocacy and lobbying

Two thirds of all survey respondents (n=20) were aware of at least one organisation actively advocating at national level for policy and/or legal improvements in adolescents’ access to SRH services. The remaining third (n=10) either said there were no organisations engaged in ASRH advocacy at national level, or they did not know of any. Examples of organisations advocating for ASRH ranged from international agencies such as UNFPA and WHO, through international NGOs like Pathfinder International and International Planned Parenthood Federation (IPPF), to national civil society and professional organisations such as family planning associations and health providers at youth health clinics (FSUM in Sweden).

#### **Question N<sup>o</sup> 26 What has been the participation of the Professional Associations in the ASRH services development in your country?**

<b>Question N<sup>o</sup> 26</b>	Active Societies or	Societies have had a strong participation and in fact, all the adult country representatives are outstanding members of the PAG societies, and their regional representative ALOGIA. Of 14 country representatives, 7 have been assessed by IFEPAG and are Fellows of FIGIJ.
Why has been the participation of the Professional Associations in the ASRH services development in your country?	Participants : 11	
	Scarce participation : 2	
	No answer : 3	

National associations of obstetricians and gynaecologists in Estonia, Slovak Republic, Chile, Lebanon, India, Ethiopia, Nigeria, Italy and Sweden reported active engagement in advocacy/lobbying on ASRH. The mixed levels of success reported by interviewees reflect a) the willingness of the government to both listen to and work with external agencies; b) the strength of the national association and its level of influence; c) the level of significance accorded to adolescents, and their health, by government and wider society; and d) the wider political, religious and social environment.

Where there is a clear long-standing, or even relatively recent, political acknowledgement of the importance and needs of young people, a political willingness for inter-agency collaboration and active organisations national associations report being able to contribute to and influence policy development. This was particularly evident in the Western Europe, and Europe and Central Asia region responses.

*"I think it (ASRH) is a subject which is not very popular among politicians because Poland is very Catholic country and the Catholic Church avoid to discuss about the sexual activities of adolescents and sexual health centres for sexually transmitted diseases... We try to publish our idea in papers and sometimes we take part in TV discussions and we also are in close cooperation with the parliament group of women". (Poland)*

*Yes, they invite... they invite us to look usually; but sometimes*

Other respondents reported a limited level of input into policy. This was perceived as sometimes taking the form more of requests for approval of policy rather than active participation in its development. In other instances the influence of more powerful bodies such

as the church, whose interests were seen to conflict with sexual and reproductive health care – particularly contraception and abortion services, was perceived as limiting participation by less powerful professional associations:

Other interviewees reported that the opportunities for professional associations to raise its profile are very limited, if national or federal governments do not view ASRH as a priority issue. It appears that the majority of inputs from professional associations are reactive, i.e. in response to requests from government, rather than influencing government awareness of a need to introduce policies specifically addressing the sexual and reproductive health needs of adolescents.

*"We just feel that the Government hasn't taken the health issue into the priority aspect ... Some of the states in India still are quite conservative ... So there are certain barriers because the state is in charge. Each state is kind of, you know, responsible, and the Government deals according to what they feel. The states which are conservative are a little more difficult to approach." (India)*

*"You can distribute pamphlets, you can distribute newsletters. But remember, they're only going to be as good as those who read it, and those who've got any strength of doing anything. I think that the whole aspect, or the collapse of a large number of the services is that there's no political buy-in. So you can write, you can publish, you can put up posters - beautiful. But unless there's political buy-in within the countries themselves..." (South Africa)*



*"I think that FIGO should, um, should take some, what we call positions, official positions which should be sent to the parliament of the, of the nations, especially to the European Parliament and, and eventually, I mean local parliament for countries. Just letting the parliament know that FIGO took such a position and this is a nice way to, to make lobby in favour of sexual and reproductive health of adolescence ... Just an official position from outside, from an international well-known and good reputed [sic] institution, like FIGO, could help local, um, scientific societies dedicated like ours to gynaecology in order to force local governments to endorse and, er, and just to be more pragmatic in order to realise this strategy". (Italy)*

*Assistance from FIGO would be very helpful. While the government is supportive of ASRH policies and programmes ...support from FIGO would be welcome. It helps him to have international links which gives him greater authority, so he can push for greater change. (Morocco - interview notes)*

*"FIGO should help in creating awareness ... Lobby... lobby, not only our government, lobby to those governments who are donors, you know, and our government have to listen to them". (Pakistan)*

*"Having this recommendation, you know, policy recommendation number one, helps obgyn doctors to practice that way, to use it as a reference for their policy recommendation in the country. An*

FIGO was seen by many interviewees, both from countries where national association influence is limited and from those where associations do contribute to policy development, as having a clear role to play in its international capacity. It was felt that a potentially influential output would be publication of position papers, short evidence-informed policy briefs addressing specific policy concerns etc., would provide important international credibility and support to national efforts. These documents could then, additionally, be adapted to be specific to national contexts.

The results of the survey strongly support these suggestions made during the interviews. A total of 93% (n=27) of respondents felt that obstetricians and gynaecologists should play a role in advocacy for improvement of ASRH, and 97% (n=28) thought that FIGO should actively engage in lobbying.

While policy is clearly important in order to provide rights to adolescents and a framework for service delivery, as many respondents to the survey and interviews described, it is insufficient to guarantee adolescents access to services. The following section shows clearly that there are major gaps in implementation even in countries with relatively well developed policies.

## **4.2 SERVICE DELIVERY**

### **4.2.1 Equality of access**

Not surprisingly when respondents were asked about equality of access to services for male and female, and married and unmarried adolescents, the responses identified greater levels of inequality than were reflected in their response to adolescents' rights.

Sixty five percent of respondents (n=19) reported that male and female adolescents do have equal access to services, 27% (n=8) said they do not, while 2 (7%) were unsure. There were clear, and unsurprising, regional variations in response to this question. One hundred percent of respondents (n=6) from the Western Europe region, and 71% from the Europe and Central Asia region reported gender equality in access to services. In contrast, out of 15 countries in East Asia & Pacific, Latin America and Caribbean, Middle East and North Africa, South Asia and Africa regions, 53% said that male and female adolescents were equally able to access services. This figure appears relatively high and may be due to respondents being based in urban settings where access is easier than in rural areas.

In the Latin America and Caribbean region access was reported to be easier for girls than boys – due to a perceived structuring of services specifically to address female adolescents' health needs; while in other regions boys had greater access than girls as a result of social and religious restrictions on girls movements and health seeking behaviour, compounded by health professionals negative attitudes towards girls seeking information or care.

**Question N° 27 What is your experience in the access of boys and girls to SHRA Services in your country? AND Married and single adolescents?**

<p><b>Question N° 27</b></p> <p>What is your experience in the access of boys and girls to SHRA Services in your country?</p> <p>AND Married and single adolescents?</p>	<p>Non or scarce Experience: 14</p> <p>No answer : 2</p> <p>Non Differences in access: 6</p> <p>Scarce experience: 3</p> <p>No Answer: 7</p> <p><b>Adolescents:</b></p> <p>6 answers say Programs are for girls mainly</p>	<p>There is definitely an outstanding debt with ASRH services, because boys have little access and efforts to include them are still weak and unstructured. There is no training in attention for Adolescents. What experiences there are, are isolated and non-systematic.</p> <p>In general, the issue of married adolescents was not discussed. Because they attend regular healthcare systems and their status is not a condition of non attention in the ASRH care services of the countries represented. This question came as a surprise because they never thought that it would be a barrier for healthcare.</p>
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Responses to married and unmarried adolescents' perceived ability to access health services were also similar. Sixty percent (n=18) of respondents reported that married and unmarried adolescents have equal access to SRH services; 32% (n=11) said access was unequal.

*"Even where access is not restricted by law, family planning services often have policies against serving unmarried people" (India)*

*"As unmarried pregnancies are still looked down on by the society, stigma may delay accessing services and late entry to care. In the private*

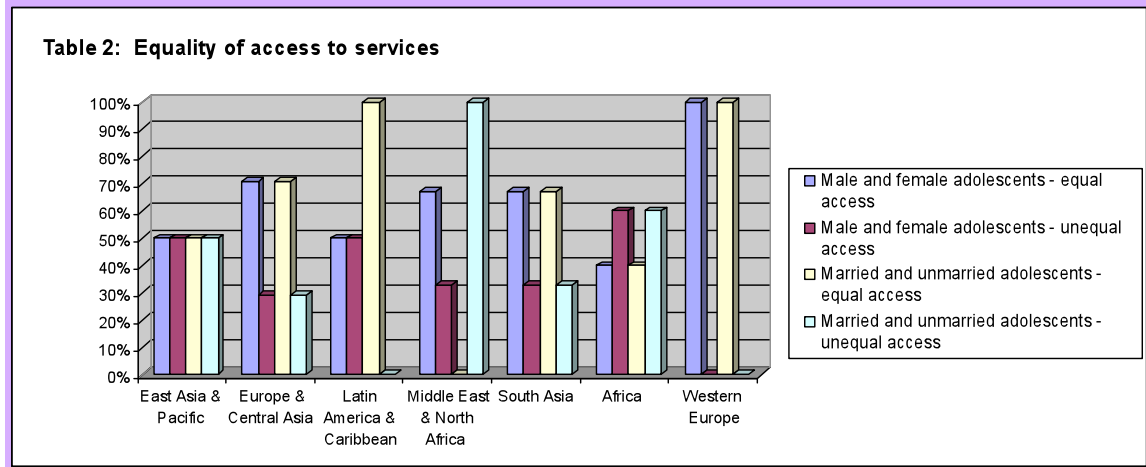
*"Technically they have equal access but the attitudes of society, including their parents, teachers and the stigma attached to SRH issues (means) access may be limited particularly to girls" (Sri Lanka)*

*"The structure of health (service) allow much more access to females than males" (Chile)*

*"Female services represent about 80% and for males 20%." (Venezuela)*

*"If someone sees her to go to that clinic they can*

All respondents (n=8) in Western Europe, and Latin America and Caribbean regions said married and unmarried adolescents were equally able to access SRH services. All respondents in the Middle East and North Africa region (n=3) reported that access to services was impossible for unmarried female adolescents. In the remaining regions 44% of respondents said that access was unequal – with female adolescents generally having lower levels of access (Table 2).



#### 4.2.2 Provision of services

We asked respondents what they thought worked well, in terms of ASRH services, in their country, and what did not work well – and why. Many countries have no specific ASRH services. In these cases respondents described aspects of primary health care and public health approaches which are used by adolescents.

The most consistently reported aspects were *specialist services*, often called youth friendly services (YFS) or adolescent friendly clinics (AFC); or specific adolescent services provided by national family planning associations (FPA). These were positively described by respondents from a number of regions including Europe and Central Asia, North Africa and the Middle East, and South Asia.

In parallel with this, *specialist staff*, ranging from adolescent peer educators through to health professionals such as counsellors, psychiatrists and physicians, were also reported to provide the best services available to adolescents in each respective country.

#### What works well in terms of ASRH services:

*“Introducing the youth friendly services (YFS) concept, peer education, voluntary counselling and testing (VCT).” (Bulgaria)*

*“Youth friendly SRH services – since 1991 youth clinics have provided free contraception counselling, STI/HIV testing, and sexuality education lectures; youth internet counselling – through ESHA web-page [www.amor.ee](http://www.amor.ee).” (Estonia)*

*“Youth-friendly services (including SRH); strong counselling/resource centres”. (Lebanon)*

*“Physicians and psychologists who work with adolescents are very good specialists”. (Lithuania)*

*“Adolescent friendly clinic. It needs to be strengthened and expanded”. (Nepal)*

**Question N<sup>o</sup> 28 ¿What is the best / worse , on ASRH for your country?**

<b>Question N<sup>o</sup> 28</b> ¿What is the best / worse on ASRH for your country?	<b>ADBADW AdB AdW</b>			
*Girl Counselling	1	<b>11</b>		
*Boys Counselling	8	4		
*Family Counselling	1	8		
*Prenatal Care	<b>1</b>	1	<b>8</b>	
*Posnatal Care	<b>2</b>			
*Posnatal Care	9	3	8	
*NB, BreaFe.Care	<b>1</b>	2	<b>8</b>	
	<b>0</b>			
*Cont Pre.Rep Pr.	7	4	8	
*Cont Pre. 1 <sup>st</sup> prg	7	3	8	
*abortion Counse.	4	8		8
*Misoprostol Ad	0	<b>9</b>		8
*Postabortion Car	3	6		8
*Adopt.Counsel	1	<b>9</b>		
*Adopt. Process	1	6		
*STI Prevention	7	2	8	
*STI Dia g/Treat	7	3	8	
*PAG	3	6		
*Boys Care	1	<b>10</b>		<b>8</b>
*Sexuality Orient.	3	8		8
*GenDef/ Hom.O.	1	<b>9</b>		<b>8</b>
* Transexualism	1	<b>10</b>		<b>8</b>
*Sex. Harass Con.	1	<b>10</b>		<b>8</b>
*Sexual Abuse	1	<b>10</b>		<b>8</b>
*Mental Hea. Sup	2	<b>9</b>		
*Social Work Sup	4	7		
ADB/ADW= AduBest/Adul Wor				
AdB/AdW= Ado.Bes/Ado.Worse				

In general there was consensus in terms that maternal infant areas are the best, while everything related to abortion, Misoprostol and human sexuality is the worst. Adults and adolescent/young representatives agreed on these points. It was unanimously agreed that each developing programme should reinforce its weaker components, especially in the area of abortion prevention (in accordance with the laws of each country), healthcare for male youngsters and adolescents, and sexual abuse issues. All this requires attention regulations that are urgent, as is training in these areas.

In only two countries, both in the Western Europe region (England and Sweden), was multi-disciplinary and collaborative working viewed as working well.

Not surprisingly, where appropriate educational materials, good resources and skilled staff were available they were perceived as working well. Whether or not they have been evaluated as effective and whether they are being implemented at scale is beyond the scope of this study to investigate. What is important, however, is that they are viewed as being more effective and appropriate than services which may be accessed by adolescents but are not designed or provided with adolescents<sup>2</sup> specifically in mind. This reflects the findings of the literature review (Section 3).

<sup>2</sup> N.B. adolescents are not a homogeneous group. Adolescents may be male, female, married, unmarried, in-school or out-of-school, live in conflict or post-conflict zones, rural or urban settings, or belong to marginalized populations. Respondents did not specify which adolescents accessed these services.

**Question N<sup>o</sup> 29 In your experience Which are the deficient areas of professionals and support perssonel that attend adolescents?**

<p><b>Question N<sup>o</sup> 29</b></p> <p>In your experience Which are the deficient areas of professionals and support perssonel that attend adolescents?</p>	<p>Mental Health Social Health, Sexuality and Boys management</p> <p><b>Adolescents:</b> Lack of Adolescent Services Lack of Sexual Education Lack of Health personnel Training</p>	<p>This question and the preceding question N<sup>o</sup> 28 coincide in terms of deficiencies in the field of attention and lack of training.</p>
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The list of what does not work well in terms of ASRH services was much longer. Specific aspects of care were highlighted such as abortion services, access to contraception and follow-up care. However, the two most frequently cited aspects were school-based sex education programmes (due to inadequate training of teachers, lack of time), and deeply embedded social, cultural or religious disapproval of adolescent sexual activity. These attitudinal issues were also described as preventing staff at government run health facilities from providing sensitive and appropriate information and care based on non-judgemental, listening and discussing, and adolescent-friendly values (see Section 4.4).

A wide range of professionals were described as providing ASRH services. These included health professionals such as nurses, midwives and physicians, specialists such as obstetricians, gynaecologists and psychologists; and non-health professionals in the form of teachers, counsellors and peer educators.

The majority of respondents, when asked who should provide adolescents with sexual and reproductive health information, education and support identified professionals (health or non-health) with training and specialist skills in communicating with adolescents; who were easily accessible; and were 'appropriate' in terms of having regular close contact with a range of adolescents. For example, teachers were seen to have an important role to play (providing they were appropriately trained) in providing health and, in some cases, sex education; peer educators were viewed as non-intimidating and having a shared understanding of, and empathy towards, adolescents' needs for information and access to services; and health professionals, obviously, are most appropriate to provide clinical care. This wide spread of responses represents the diversity of cultures and environments within which respondents live and work, but also suggests recognition of the breadth of sources of information that need to be available to adolescents and the benefits that could be achieved through a multi-disciplinary, adolescent-centred approach, although only 27% (n=8) of respondents, mainly from

Europe and Central Asia, and Western Europe regions reported that key

**What does not work well:**

*“Providing services to adolescents through general regular health facility”. (Nepal)*

*“Comprehensive services including youth (youth may not be encouraged, providers are not sensitive).” (Lebanon)*

*“Nobody is identified to deal with ASRH issues”. (Sudan)*

*“Improvements are needed to attract more male visitors, which requires more education among providers”. (Sweden)*

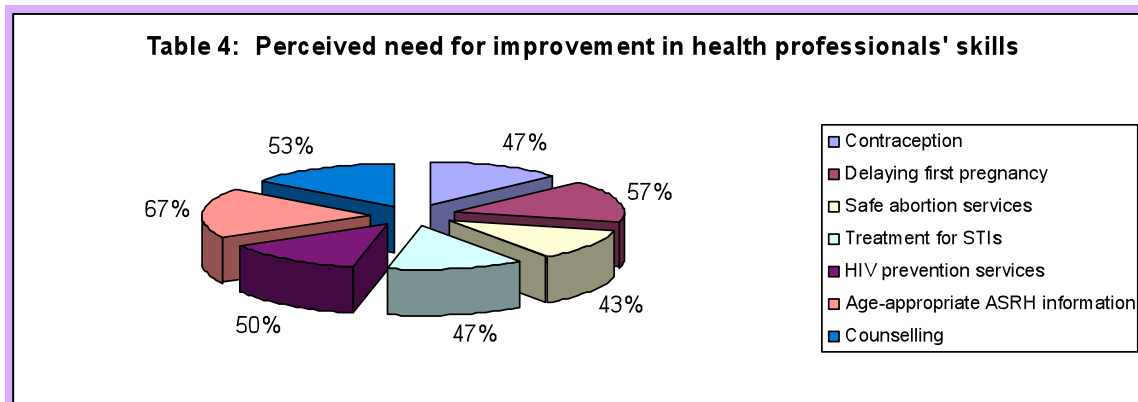
*“Male counselling” (Chile)*

*“National program of sexual and health education - bureaucratic obstacles and lack of understanding from the Ministry of Education” (Bulgaria)*

professionals work well together, with effective referral services and professional networks.

Respondents were also asked which major ASRH issues would benefit from improvements in health professionals' skills. Table 4 shows that providing age-appropriate ASRH information, education and support was the area in which there was the greatest need for skills improvement. Overall, however, there was a relatively similar spread of perceived need for skills improvements across a wide range of key issues in ASRH. The least perceived need for skills improvement was in enabling adolescents to access safe abortion services, however, this is likely to reflect the

number of countries in which abortion is illegal and thus skills improvement in other areas would take priority.



The relatively low priority attached to improving health professionals skills in helping adolescents access HIV prevention services (including VCT) is largely due to regional variations. All respondents in the two regions worst affected by HIV & AIDS (Africa and Latin America and the Caribbean) said professional skills should be improved in this area. Fifty percent of respondents in East Asia & Pacific and the Middle East and North Africa supported skills strengthening; whereas the other regions, in which fewer than 50% of respondents said professionals skills needed to improve in this area have generally lower prevalence rates.

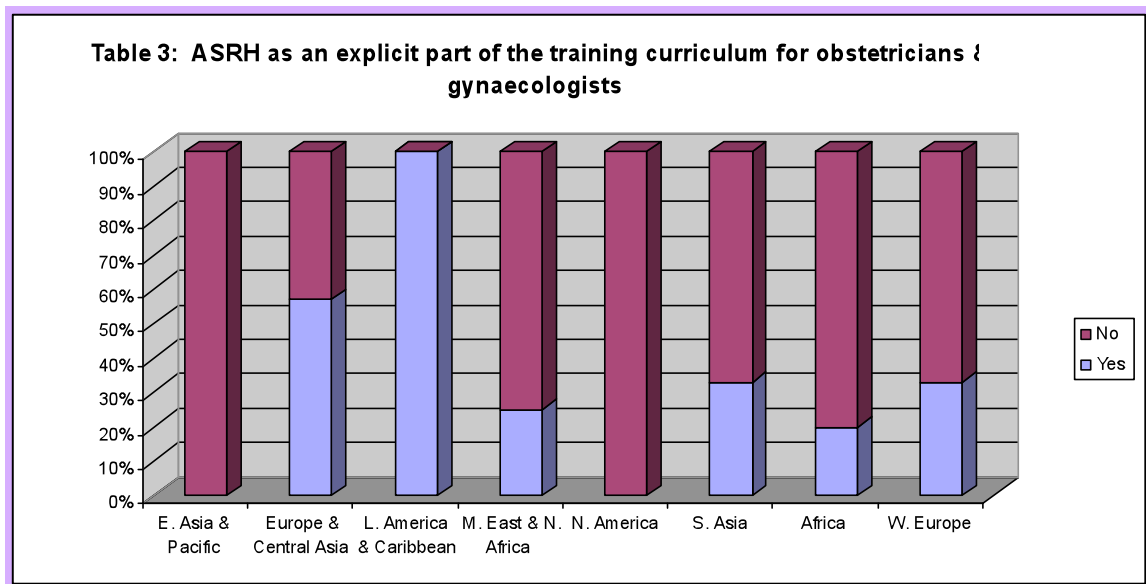
Age-appropriate information was perceived as covering issues ranging from information on puberty, body changes and sexual urges through to the physiology of the reproductive system

All respondents except one (97%) viewed FIGO as having an essential role to play in supporting improvements to ASRH through development of standards of clinical practice and technical guidance.



### 4.3 PROFESSIONAL TRAINING AND EDUCATION

Thirty seven percent of respondents reported that ASRH forms an explicit part of the training curriculum for obstetricians and gynaecologists. The regional breakdown of data (Table 3) should be treated with caution due to the small sample size (for example only 10% of FIGO country members from the Latin America and Caribbean region responded to the survey), however the overall picture is indicative of the low priority given to ASRH in pre- and in-service training



Respondents knowledge of whether ASRH is included as part of the training curriculum for other key health professionals e.g. doctors, nurses, HIV&AIDS specialist health workers etc., was less certain, with 17% (n=5) not knowing whether or not it was included. Other than that, a similar overall pattern was seen with, again, only 37% of respondents reporting its inclusion. Israel, Iceland and Italy reported that ASRH was not part of the training for obstetricians and gynaecologists but was included in the training curriculum for other key health professionals.

Despite some respondents' anxiety about the difficulty of introducing ASRH into pre- and in-service curricula, there was a very high level of support (90%) for FIGO to become actively involved in

*“How do you get it there, into the curriculum? That is the issue, you see. Because there are also people that are going to decide what gets through the curriculum or not. ... Do those people really think that adolescent health is an important issue? If they don't then there is no amount of pressure that you can apply that is going to get you something there.” (Ethiopia)*

the development of training modules. There was no clear consensus of opinion, however, regarding the users of these training modules i.e. specifically obstetricians and gynaecologists, or a broader range of health professionals who are more directly involved in providing services to adolescents. A range of opinions was also expressed as to whether it would be more cost effective for FIGO to support increased utilisation of existing curricula and modules (those developed by WHO and Pathfinder were most widely known); or whether FIGO should invest in the development and testing of training tools for clinical specialists.

**Question N° 30 In your experience: ¿How do you train in Service personnel on ASRH? What’s institution should be involved in this training? Is it possible to involve Medicine Faculties? Is it best accepted training with postgraduate certification ?**

<p><b>Question N° 30</b></p> <p>In your experience: ¿How do you train in Service personnel on ASRH?</p> <p>¿ What’s institution should be involved in this training?</p> <p>Is it possible to involve Medicine Faculties?</p> <p>Is it best accepted training with postgraduate certification ?</p>	<p>Theoretical and practice Workshops, in continuous education</p> <p>All related Institutions : 16</p> <p>All Medicine Faculties: 16</p> <p>YES : 16</p>	<p>Unanimous agreement was expressed on the subject of training, which had already been amply discussed in previous questions.</p> <p>It was added that Medical Faculties should make great efforts to include in their curricula ASRH Concepts and management, and ASRH as a right.</p> <p>In this way, all specialist Congresses should include these issues for dissemination and in-depth discussion.</p>
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Generic/Existing Training Tools		Specialist/New Training Tools	
<i>Advantages</i>	<i>Disadvantages</i>	<i>Advantages</i>	<i>Disadvantages</i>
Already developed and tested.	Insufficiently specialised for different health professionals	Cover specific skills/clinical practice in detail	Need to be developed and tested – takes time and money
Credible due to international organisation label	No sense of ownership by professional associations.	Respected obstetric/gynaecology association label e.g. FIGO/RCOG creates sense of ownership and respect	Limited number of beneficiaries
Can be adapted for specific national contexts		Can be adapted for specific national contexts	

*“One training could be held by FIGO or FIGO members and we could activate such programme and such programme should be continuously running through the continuous medical education”. (Georgia)*

*“WHO is having the curriculums for the training of health workers. But that’s not regularly done ... FIGO could help, you know, providing these kind of trainings at the grass roots level with the health workers who deal with the, you know, grass root people. You know, that could be something which would really be of great help with the system that we have right now”. (India)*

*“Whatever the material that somebody develops, which is to be used across all countries and suitable for all countries, I think there must be some provision for some kind of adaptation to that*

The need to make training tools fit national legal, religious and cultural contexts was acknowledged by all respondents. It was felt that FIGO could significantly add value to either new or existing tools by investing resources in national associations to do this. Also, it was pointed out, there is a need to match the development and promotion of tools with large-scale, well targeted, skilfully facilitated training workshops/sessions – and several respondents suggested that financial and practical help from FIGO to do this would be valuable.

Respondents also reiterated that training should have a broader perspective than purely clinical care. They viewed it as essential that a training module should include social aspects of health; and a very clear focus on male and female adolescents' needs.

A note of caution, particularly from interviewees in the Africa Region, was inserted into the overall support

*"You maybe don't need so much high level professional skills, but more like sophisticated thinking about delivering services and having nurses and midwives well trained, and ready to deal with different issues, maybe not on the high level ... they can refer if they can find some very specific problems. I think working in youth friendly health services you have to be trained in a little bit broader view about everything ... And then it is not only about girls' gynaecological care, but you can think about how to involve boys as well and what are their needs". (Estonia)*

*"I knew about how to deal with it medically as a gynaecologist, but then I learnt there are more things like counselling; communicating was another thing; the life skills which are never in our curriculum in my whole of, maybe ten years of medical school. I never knew about this life skills. But that added to my own knowledge of understanding what adolescents really need". (India)*

*"I think the WHO division of obstetricians and gynaecologists, what they did was they trained some of the obstetricians in counties like ours, including myself, on how to conduct workshops. They were teaching a methodology. So, once that happened and a lot of us got trained ... we took up the issues and carried on the similar teaching. This is why I pointed out that obstetricians have the know how, the members have the know how about these problems and the medical part of it, but ...by knowing, it doesn't mean that I can provide a service to an adolescent; I think that is quite different to having the knowledge. So, I know*

**Question N<sup>o</sup> 31 Should be involved in this Training on SHRA to Obstetrics and Gynecological Societies or PAG?**

**Should be adequate the coordination between FIGO, FIGIJ and WHO in the SHRA area?**

**Should be adequate the coordination between FLASOG, ALOGIA and PAHO in SHRA in the Region of Americas?**

**Which is your experience in Long Distance ,On Line training Programs on ASRH? The Spanish language is speaking in all Region and it can be translated to Portuguese.**

**Do you believe adequate to give an space to children attendance, within the SHRA Services?**

<p><b>Question N° 31</b></p> <p>Should be involved in this Training on SHRA to Obstetrics and Gyneacological Societesor PAG?</p> <p>Should be adecuate the coordination between FIGO, FIGIJ and WHO in the SHRA area?</p> <p>Should be adecuate the coordination between FLASOG, ALOGIA and PAHO in SHRA in the Region of Americas?</p> <p>¿ Which is your experience in Long Distance ,On Line training Programs on ASRH? The spanish language is speaking in all Region and it can be translated to Potuguesse.</p> <p>Do you believe adecuate to give an space to children attendance, within the SHRA Services?</p>	<p>YES : 16    <b>Adolescents:</b> All agree</p> <p>YES: 16    <b>Adolescents:</b> All agree</p> <p>YES: 16</p> <p>Positive : 11    <b>Adolescents:</b> 3 with Exper.    But all agree Negative: 1 No experience: 3, but it is an useful tool No answer :1</p> <p>YES: 2            <b>Adolescents :</b> NO : 9            YES: 4 NO Opinion: 0        NO : 4 No Answer: 5</p>	<p>All the participants agreed that Societies play an essential role in ASRH training and dissemination,, although there are certain societies that have focused more on highly specialised clinical aspects or that have had a very collateral participation in these actions, which are managed by the society, neither have they given much support to Ministry or State organisations.</p> <p>Coordination is essential in order to avoid replicating activities and to make better use of resources. All the Agencies are interested in the subject and it is important to involve the best critical mass in the Region.</p> <p>FLASOG is developing a strong component in the area of ARSH and is already working on specific projects on the production of further information on pregnancies in girls under 14 years of age, on the regulation of sexual abuse in adults, children and adolescents and on violence against women. It is also working on ASRH curricula for Faculties of Medicine. PAHO shares this interest, and FIGO has focused on the prevention of Unsafe Abortion. It is indispensable for Federations to get in touch and work in a coordinated way, and National and Regional congresses should be used to develop lines of coordination and show results.</p> <p>In the region there are two or three cases of Distance Training, like SAGIJ in Argentina, the Faculty of Medicine of the University of Chile, in Chile, while Colombia and Mexico are still developing the subject. These efforts should be strengthened and experiences should be exchanged and shared, and resources should be applied for so as to be able to offer them to more Health personnel.</p> <p>As for the inclusion of children in Adolescent Services, there was a shared opinion that what is required is closer coordination with Paediatrics services and more specifically with attention in the area of Child Gynaecology, which is not common. In fact, this is what is happening in Argentina, Brazil, Chile, Uruguay, Colombia and Panama.</p>
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for developing/implementing pre- and in-service training. Many FIGO country associations are working in severely resource constrained environments, where health professionals are often de-motivated, frustrated and faced with stock-outs, staff shortages and poor working conditions. Although it is beyond the remit of FIGO to improve the structure of health services, this may impact on the effective implementation of professional and clinical training.

**Question N° 32 What is the information limit to be given to adolescents, by the professional in a Service of SRHA?**

<p><b>Question N° 32</b></p> <p>What is the information limit to be given to adolescents entregada by the professional in a Service of SRHA?</p>	<p>Complet in relation with needs of outpatient : 13</p> <p>No Answer :3</p> <p><b>Adolescents:</b> 8 agree with needs of Adolescents.</p>	<p>There was unanimous agreement on this matter, and it was recommended that according to the opinion of the professionals in charge, ample information should be provided, and be limited only by the demands of the patients. Emphasis was placed on the fact that in this area there are ideological, philosophical, political or religious biases that go against the personal rights and Ethics.</p>
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*"You can train as many people as you want to. You can convince the guy on the street at the ground level, but if you don't have the facilities, it's not going to work." (South Africa)*

*"I think it's very, it's very important ... It's like, let's say it's a starting point, because how can you care about adult women's sexual reproductive health if you haven't taken the problems of young women and young girls? So, I think it is the starting point to improve reproductive health. For me it is crucial actually. You can't like separate them and you can't work with only adult women's problems". (Estonia)*

*"It is very, very urgent and FIGO should concentrate on that problem, not only in the developing countries, but also in developed countries". (Poland)*

*"I think FIGO should put more energy into safe motherhood. I think you'll find this ASRH is good, but I think for us the safe motherhood would be much more acceptable, especially for developing countries". (Tanzania)*

*"In developing countries this (ASRH) is the most important thing because it will form the future population. ... This is very important, the most important I think. If this can happen unsafe abortion, safe motherhood will also be affected by this project because the individual will be knowledgeable in the future and the other things will be helped automatically". (Turkey)*

**4.4 ATTITUDES TOWARDS ADOLESCENTS**

The interviews revealed much information about attitudes to adolescents, and the way these impact on adolescents' ability, or willingness, to access services. Interviewees were also asked a wider attitudinal question – how important is it for FIGO to explicitly address ASRH, given its existing commitments?

**4.4.1 How important is ASRH?**

Nineteen out of twenty two interviewees perceived ASRH to be a critical issue for FIGO to address. The reasons given for this were: a) the global level of mortality and morbidity among adolescents; b) the impact that adolescent health/ill-health has on health in later life; c) the intrinsic links between ASRH and FIGO's existing priorities e.g. safe motherhood, post partum haemorrhage, and obstetric fistula.

As has been described in the sections above, the key areas in which FIGO was perceived to have the greatest potential for significant impact were: policy (advocacy and lobbying); pre- and in-service training; and development of guidelines and standards for clinical practice. Interviewees generally felt it would be inappropriate, and impractical, for FIGO to become actively involved in service delivery issues in individual countries. Two interviewees said that project funding would be useful but generally the overall opinion was that FIGO only has limited experience in project implementation and management, and individual country associations lack the time and skills to run projects. However, FIGO was perceived to have a potential key role to play in leading or participating in coalitions and partnerships.

#### 4.4.2 Social, cultural and professional attitudes

The obstetricians and gynaecologists participating in this study are neither

*“Ninety-nine percent of gynaecologists are working in the city. They’ve no idea of what’s going on in the rural part of the country, no idea. ... they’ve no idea about the communication problem, about the transportation problem, about the local custom, about some very bad cultural tradition. You know, these people have no idea what’s the real problem faced by these rural women.” (Pakistan)*

representative of the societies within which they live, nor of health professionals working in these countries. In developing countries the majority of health professionals are based in rural areas, in primary health care facilities and would have very limited access, if any, to current professional debates, evidence or training. As a result, the very pro-

adolescent perspective of our interviewees is likely to be far stronger than if we had based our interview sample on community based primary healthcare workers. FIGO, however, is the federation which represents obstetricians and gynaecologists but many of the views expressed during the interviews reflected the broader attitudes within society – and also explained the difficulty associated with trying to change attitudes and practice on such a contentious and sensitive subject as adolescent sexual health.

*“You can’t threaten a whole society system ...100 gynaecologists totally, 2,000 doctors, maybe 10 economists and so on, you know. Maybe total 50,000 with degrees out of 80 million people. So it is clear that this is a traditional society basically. ... So whether you have a PhD or not your attitude is going to be like the society, and most people with PhDs that I see, I don’t see a basic fundamental difference in their attitude from the rest that do not have PhD’s as far as I am concerned. ... And I don’t expect them to, because they have to survive you know. If you are living among 10,000 people you have to behave like the 10,000 if you want to survive”. (Ethiopia)*



### *Attitudes to 'adolescence'*

A few interviewees pointed out the difference between physiological and cultural perceptions of 'adolescence'. While the physical changes of puberty are identical, it was suggested that cultural perceptions of 'adolescence' could be perceived as eurocentric. In countries where girls marry at a very early age, for example Lebanon and Ethiopia, they go straight from being perceived as children to being 'wives' and 'mothers'. This may, at least partially, account for some respondents to both the survey and interviews not perceiving adolescents as having specific needs, different to those of adult men and women.

*"I think that 'adolescents' in developing countries is not, not the same concept we have in, um, let's say developed countries. ... Because maybe a 13, 14 years old young woman, who is an adolescent in Italy, could be a mother in some other countries. And so I think the only thing that makes the difference in terms of policies dedicated to these kinds of, ah, slice of the population could be awareness and education very early and very basic. Just to let the women, and young males, to be informed about sexual health, I mean biological family planning, and so on. Very, very early and very simple. Because I think that, um, a girl becomes a woman without even understanding what's going on". (Italy)*

### *Attitudes to gender*

The powerless, lowly valued and vulnerable position of adolescent girls in many societies was, not surprisingly, one of the key attitudinal factors described during the interviews. Interviewees described prejudice against girls in the attitudes of

*"Female genital cutting is a huge issue in this country. Gender based violence is a huge issue, although it is not called violence. Sort of accepted by the society, and you can't even call it violence, but it is a huge issue. Then there is this issue of abduction marriage. It is not illegal. Somebody organising four, five people and just grabbing a young girl and taking her to his home is not illegal. I mean it is not shunned by society, you see. Illegal of course, but not shunned by the society, so in large areas of the country it is just acceptable". (Ethiopia)*

*"Between the girls it is a shameful discussion to talk about such things, you know ... culturally it is a shameful issue to be talking about". (Jordan)*

*"They are allowed to go (to health centres), but things regarding family planning, for example, use of contraceptive, use of condoms, this will be top secret and they will do it in other ways, not in the public sector". (Sudan)*

governments, social and cultural institutions, communities, and individuals.



They were very aware of the impact this has on girl's ability to access health care as they are faced with restrictions on leaving the house alone, fears about lack of confidentiality, facing overt disapproval from health professionals, stigma and possible physical harm if her reputation within the household and community is damaged. Girls are, therefore, acknowledged to be not only marginalised from accessing services but also forced to seek information and care from outside the public sector.

As a result of adolescent girl's vulnerability and marginalised status many programmes focus on increasing their access to health services and information. Respondents fully supported this, but described an unintended consequence of these programmes as having left boys unable to access services specifically designed

*We focus more on the girls. The programmes are based on girls, we try to educate girls. Being a gynaecologist, yes, my attention would be to work with them, but the boys are to some extent neglected. (India)*

*"The programmes are much more with girls than boys. They seem to be more attuned to girls' issues because of high rates of pregnancy and complications". (Morocco – interview notes)*

for adolescents, and recognised a need to redress the imbalance.

### *Attitudes towards information*

The frequently described negative or judgemental attitudes of health professionals and parents towards giving adolescents sexual and reproductive health information was frequently described as being underpinned by anxiety about the impact of this information on sexual behaviour. There is no evidence for this (see Section 3) but many, including both parents and health professionals, believe that lack of

*“The religious and cultural issues bring out the concerns of the parents: if you talk about this the children will go astray more; you know that kind of fear is brought up”. (Sri Lanka)*

*“I'd say some of them (professional colleagues) would say that they (adolescents) should have the contraceptives. But there are a number of them I think they will also disagree. Ah. I think there are some differences in whether to accept or not to accept for the adolescent to have access to family planning methods ... for if they use contraception they are likely to have maybe a better life and avoid the unnecessary pregnancies. But then they will say then they also allow them to have sex. It means we'll expose them to HIV and Aids.”. (Tanzania)*

knowledge is an effective deterrent.

The attitudes expressed in this study are those of senior professionals working largely in urban settings. Their responses reflect personal views, not necessarily the formal opinion of their country association. However, the consistency with which many of the challenges facing both adolescents and service providers were described reflects a shared concern about sub-optimal care and services. The responses also demonstrate a widespread desire for improvement, recognition of where many of the difficulties lie, and constructive suggestions of areas in which FIGO could provide support to its member associations.

**Question N° 33 How is it possible to increase the current Training capacity in the Region on SHRA?**

**Is it possible to increase the actions between Obs &Gynec Adults Societies with PAG Societies?**

**There are 16 Societies on PAG in the Region and there are 2 Regionals Federeration of the Adults and Adolescents Specialties. Is it possible a coordination of them? Is it possible not consider the Paediatrics Societies who cover children and young people until 15 o 16 years old**

**The pediatrians start with the puberty care and it is the first period of the ASRH.**

<p><b>Question N° 33</b></p> <p>How is it possible to increase the current Training capacity in the Region on SHRA?</p> <p>Is it possible to increase the actions between Obs &amp;Gynec Adults Societies with PAG Societies?</p> <p>There are 16 Societies on PAG in the Region and there are 2 Regionals Federeration of the Adults and Adolescents Specialties. Is it possible a coordination of them?</p> <p>¿ Is it possible not consider the Paediatrics Societies who cover children and young people until 15 o 16 years old?</p> <p>The pediatrians start with the puberty and it is the first period of the ASRH.</p>	<p>In Network: 15. and with Registration of Training</p> <p>YES : 15. They asked for FIGO recognition of the Specialty on PAG.</p> <p>YES : 8 NO: 4 No Answer: 4</p>	<p>This subject was amply discussed in previous points. The best way in which these societies could increase their contribution is by recognising the speciality in their countries. This should start with the recognition of local Obstetrical and Gynaecological Societies in each country, as they are older.</p> <p>Paediatrics provides a large contingent of professionals who are giving ongoing attention beyond the age of 15, as is the case in Argentina, Brazil, Chile and Uruguay given their demographic pyramids and the strong impact of the reduction of Infant mortality rates. On the other hand, the prevention of pregnancy in girls under 14 years of age begins in the Paediatric area and then in the concept of Ongoing Attention or Longitudinal Concept of the Life Course, rather than in transversal programme compartments. This leads us to making ASRH part of Paediatrics, and to the need to train Paediatricians in this area at an undergraduate and postgraduate level. This is applicable to all health related careers. In fact, the speciality of GAP is a recognised paediatric speciality in Chile as from 2010. This is also the case in Argentina and Uruguay.</p>
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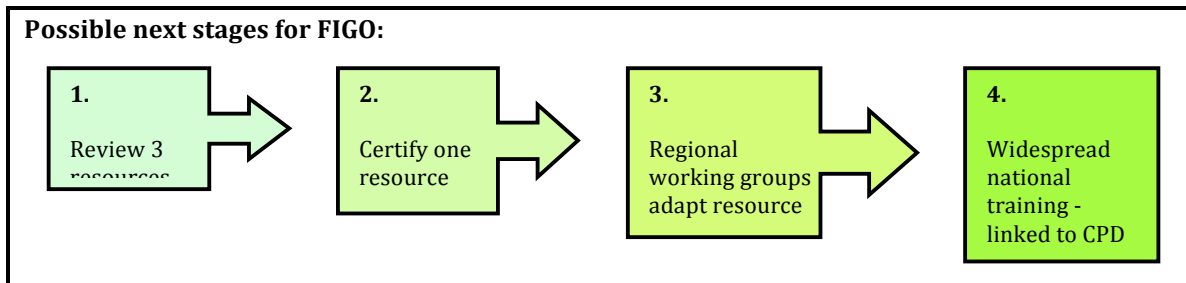
## 5. REVIEW OF TOOLS AND GUIDELINES

A selection of tools and guidelines on various aspects of ASRH were reviewed. The range of resources available is large and this review focuses on those developed by internationally respected organisations and which can be adapted for different country contexts. A framework of resources has been developed with categories covering planning, orientation, specific interventions, standards for curricula, counselling skills and peer education.

Section 4.3 describes respondents' different perceptions of training needs and how best FIGO could contribute to improvements in ASRH through their use. The main consideration for FIGO is whether greatest value can be added through development of specific tools for obstetricians and gynaecologists which incorporate both clinical and social aspects of care; or whether limited resources would be better utilised by adapting and endorsing existing tools. It does appear, whatever the decision reached, that official endorsement is important in order to increase professional credibility and encourage uptake of the tools whether in pre- or in-service training. The framework below (Section 5.1) summarises tools within a range of categories and provides links to the reference section where more details are provided, together with direct internet links. All guides and tools can be adapted for different country contexts.

Three resources in the framework have been highlighted. These tie in most closely with the information that the majority of participants requested. They are holistic in their coverage of clinical and social aspects of ASRH; they have all been tested and validated by well-respected organisations, and the resources are available free of charge in a variety of formats i.e. on-line, CD-Rom, hard copy etc. It was made very clear during the interviews that in order for obstetricians and gynaecologists to prioritise attendance at workshops and training sessions, the training must be accredited to a specialist association e.g. FIGO or RCOG, and attendance at the workshop must be certified in order to contribute towards continuing professional development (CPD).

We suggest that a small 'training and standards' working group of FIGO members should review these three resources and put the highest ranked resource forward for approval and certification by an appropriate professional association such as FIGO or the RCOG. Once certification is achieved, FIGO can then respond to requests from participants in this study to fund small regional working groups to adapt the tool for specific regions, followed by funding widespread training workshops at national level.



**Question N0 34 Do you believe that a closer coordination between FIGO and FIGIJ will be useful in the area of ASRH? Why yes? , Why No?**

<p><b>Question N0 34</b></p> <p>Do you believe that a closer coordination between FIGO and FIGIJ will be useful in the area of ASRH? Why yes? , Why No?</p>	<p>YES : 16</p>	<p>100% of the participants from the Region admit this, and for this reasons the integration of regional societies like FLASOG and FIGIJ is indispensable. ASRH related problems are far too complex and difficult to address separately. This is not a matter of professional competencies but a concept of the Life Course, which has different stages that fit together. No negative factors were detected with the exception of the medicalised concept that exists in the totally private systems that depend on the Medicine or Health Market.</p>
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**Question N0 35**

**Which is your opinion about the FIGO roles in the next areas of ASRH:**

- ❖ **Situation analysis**
- ❖ **Advocacy**
- ❖ **Policy Development**
- ❖ **Technical guidance in design of specific ASRH initiatives**
- ❖ **Quality assurance**
- ❖ **Monitoring of effectiveness**
- ❖ **Scaling up**

**Is it adequate to confront this challenge alone as FIGO? What other institutions should be integrate in this task?**

<p><b>Question N0 35</b></p> <p>Which is your opinion about the FIGO roles in the next areas of ASRH:</p> <ul style="list-style-type: none"> <li>❖ <b>Situation analysis</b></li> <li>❖ <b>Advocacy</b></li> <li>❖ <b>Policy Development</b></li> <li>❖ <b>Technical guidance in design of specific ASRH initiatives</b></li> <li>❖ <b>Quality assurance</b></li> <li>❖ <b>Monitoring of effectiveness</b></li> <li>❖ <b>Scaling up</b></li> </ul> <p>Is it adequate to confront this challenge alone as FIGO? What other institutions should be integrate in this task?</p>	<p>Rol very Important: 16</p> <p>FIGO should be communicate and diffuse his <b>rector rol and Advocacy actions</b> in the area of ASRH.</p> <p>It should be have an integration with WHO, UNFPA, IPPF, FIGIJ ,PAHO and other agencies of the UU.NN and organizations related with TEACHING, EDUCATION, WORK and SOCIAL SECURITY</p>	<p><b>FIGO plays a fundamental role in this and has a great challenge and task as an advocate at both a central level and with Societies of Obstetrics and Gynaecology.</b></p> <p>There was a prolonged discussion on FIGO's protagonism in ASRH matters and central and country actions to be taken on ASRH related issues. All agreed that FIGO has an all important role to play in this area, and in others discussed at the Workshops, and that it must disseminate its activities and exercise its role as Leader of its 113 affiliated societies.</p>
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## 5.1 Framework for tools and guidelines

Category	Tool	Purpose	Comments	Ref.
Orientation guidelines	<p><i>Orientation Programme on Adolescent Health for Health-Care Providers.</i></p> <p>(WHO, CMAT, UNICEF, 2006)</p>	<ul style="list-style-type: none"> <li>▪ Detailed guidance on organising and teaching this multi-module programme (6 core and 18 optional modules).</li> <li>▪ Focus is promoting healthy development in adolescents, and preventing and responding to health problems.</li> <li>▪ Modules cover a wide range of clinical and service related topics (all focused on adolescents) including ASRH.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed nurses, clinical officers, doctors.</li> <li>▪ Materials available: full programme; facilitators/course director's guide; lecture aids; power point slides; talking points; study materials and participant handouts.</li> <li>▪ Available on CD ROM and hard copy</li> <li>▪ Can be used to help develop national/regional strategies for YFS/AFC</li> <li>▪ English, French and Russian versions.</li> <li>▪ See below for Europe and Central Asia adaptation advice.</li> </ul>	[62]
	<p><i>Guidelines for Adaptation of the WHO Orientation Programme on Adolescent Health for Health Care Providers in Europe and Central Asia.</i></p> <p>(WHO, UNFPA, UNICEF, 2006)</p>	<ul style="list-style-type: none"> <li>▪ Provides practical, step-by-step guidance for national adaptation of the Orientation Programme.</li> <li>▪ Includes suggestions for strengthening/ including additional themes within the existing modules.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed anyone wishing to adapt the Orientation Programme.</li> <li>▪ Materials include: a checklist for planning, organizing, and following up on the national adaptation of the Orientation Programme.</li> <li>▪ Regional focus: Europe and Central Asia</li> </ul>	[63]

Category	Tool	Purpose	Comments	Ref.
Provider training curricula	<i>Standards for Curriculum-Based Reproductive Health &amp; HIV Education Programmes.</i>  (FHI, 2006)	<ul style="list-style-type: none"> <li>▪ Developing/adapting curricula.</li> <li>▪ Deals with development/adaptation, content and implementation.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at health professionals.</li> </ul>	[64]
	<i>Faith-based Family Life Education Curricula.</i>  (FHI, 2006)	<ul style="list-style-type: none"> <li>▪ Working with adults and youth of different faiths on sexuality, reproductive health, HIV.</li> <li>▪ Provides a forum to clarify religious values around these topics, while providing accurate technical information.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Anyone working with youth.</li> <li>▪ Contains curricula and manuals.</li> <li>▪ Separate Muslim and Christian materials.</li> <li>▪ Not designed to promote religion</li> </ul>	[65]
	<i>Adolescent Health &amp; Development in Nursing &amp; Midwifery Education</i>  (WHO, 2004)	<ul style="list-style-type: none"> <li>▪ Integrating adolescent health and development into curricula – contains strategies and tools to assist integration.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at nurses and midwives worldwide.</li> </ul>	[66]
	<i>Reproductive Health Services for Adolescents: Comprehensive Reproductive Health &amp; Family Planning Training Curriculum 16.</i>  (Pathfinder, 2002)	<ul style="list-style-type: none"> <li>▪ Specialist information.</li> <li>▪ Emphasis on dual protection, safer sex, counselling, care of pregnant adolescents, dealing with gender, sexual abuse and sexual orientation.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at health professionals providing services to adolescents.</li> <li>▪ Materials available on the internet, plus participant handouts.</li> </ul>	[67]
	<i>Youth-Friendly Services: A Manual for Service Providers.</i>  (Engender Health, 2002)	<ul style="list-style-type: none"> <li>▪ Sensitisation on provision of YFS.</li> <li>▪ Covers: service provider values, adolescent development, STIs/HIV, contraception, communication &amp; counselling; COPE.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at all staff at health care facilities.</li> <li>▪ All activities can be adapted for different professional roles.</li> <li>▪ Available on-line.</li> </ul>	[68]
	<i>Youth-Friendly Pharmacy Program Implementation Kit CD-ROM.</i>  (PATH, 2004)	<ul style="list-style-type: none"> <li>▪ Increasing pharmacy staff technical and personnel skills in dealing with adolescents.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at pharmacy staff.</li> <li>▪ Strong section on emergency contraception.</li> <li>▪ Available on-line.</li> </ul>	[69]
	<i>Reproductive Health of Young Adults</i>	<ul style="list-style-type: none"> <li>▪ Increases awareness and understanding of the</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at health care providers,</li> </ul>	[70]

	<i>Training Module.</i> (FHI, 2003)	reproductive health needs of young adults.	policy-makers, programme directors/planners. <ul style="list-style-type: none"> <li>▪ Available on-line.</li> <li>▪ Suitable for self-study or group training.</li> </ul>	
<b>Category</b>	<b>Tool</b>	<b>Purpose</b>	<b>Comments</b>	<b>Ref.</b>
<b>Support and counselling</b>	<i>Psychosocial Support for Children and Adolescents.</i> (WHO, 2005)	<ul style="list-style-type: none"> <li>▪ Training to adopt a non-disease oriented approach with adolescents and children.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at health and mental health professionals.</li> <li>▪ Focus on post emergency and disaster situations.</li> </ul>	[71]
	<i>Counselling Skills Training in Adolescent Sexuality and Reproductive Health: A Facilitator's Guide.</i> (WHO, 2001)	<ul style="list-style-type: none"> <li>▪ Guide to organizing and facilitating workshops to strengthen knowledge on: adolescent sexuality and reproductive health; interpersonal communication and listening skills; and principles of non-directive counselling.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at adults who counsel adolescents.</li> <li>▪ Provides information on teaching/training methods as well as developing counselling skills.</li> </ul>	[72]
	<i>HIV Counselling and Testing for Youth: A Manual for Providers.</i> (FHI, 2007)	<ul style="list-style-type: none"> <li>▪ Increasing counselling skills and sensitivity to the specific needs of adolescents.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at service providers and counsellors.</li> <li>▪ Easy-to-use, spiral bound booklet.</li> </ul>	[73]
<b>Programme planning</b>	<i>Adolescent Sexual and Reproductive Health: A Training Manual for Programme Managers.</i> (CEDPA, 2003)	<ul style="list-style-type: none"> <li>▪ Capacity-building manual for public and private sector.</li> <li>▪ Designing programmes for 10-24 year olds - reproductive health needs and rights; developing life skills and adopting healthy behaviours.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at ASRH Programme Managers and Coordinators.</li> <li>▪ Product of a south-to-south consortium programme.</li> <li>▪ Available in English and Spanish.</li> </ul>	[74]
	<i>Toolkit: Get Youth on Board.</i> (GTZ, 2008)	<ul style="list-style-type: none"> <li>▪ Outlines approaches to and examples of an integrated approach to adolescent health promotion.</li> <li>▪ Considers specific situations and problems, and socio-cultural environment.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at anyone involved in health promotion and health education.</li> <li>▪ Provides practical examples</li> </ul>	[75]



Category	Tool	Purpose	Comments	Ref.
	<i>Hands On: A Manual for Working with Youth on SRH.</i> (GTZ, 2002)	<ul style="list-style-type: none"> <li>▪ Manual on practical methods and approaches for development and implementation of SRH interventions with adolescents.</li> <li>▪ Includes step-by-step guides to different methods, approaches, peer education, IEC materials, edutainment activities, supporting youth organisations and cross-sectoral networking.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at technical cooperation personnel and development partners.</li> <li>▪ Sixteen separate but complementary papers written by practitioners.</li> <li>▪ Focus on examples and checklists.</li> <li>▪ Can be adapted to different settings and topics.</li> </ul>	[76]
	<i>Youth-Friendly Services: An Annotated Web-Based Guide to Available Resources.</i> (FHI, 2004)	<ul style="list-style-type: none"> <li>▪ Guide containing 16 tools to make programmes more adolescent-friendly.</li> <li>▪ Types of tools: planning, assessment, provider training curricula etc.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at anyone providing/planning ASRH services.</li> <li>▪ Includes easy Web links to resources.</li> </ul>	[77]
<b>Peer education</b>	<i>Youth Peer Education Toolkit.</i> (FHI, 2006)	<ul style="list-style-type: none"> <li>▪ Development of sustainable and effective peer education programmes.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at programme managers and master trainers.</li> <li>▪ Research/evidence-based, local examples.</li> <li>▪ Designed for adaptation to different settings.</li> </ul>	[78]
	<i>Guide to Implementing TAP (Teens for AIDS Prevention): A Peer Education Programme to Prevent HIV &amp; STI.</i> (Advocates for Youth, 2002)	<ul style="list-style-type: none"> <li>▪ Step-by-step guide to implementing an HIV/STI prevention peer education programme</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at programme planners.</li> <li>▪ Can be adapted for schools, faith communities, AIDS organizations, and community-based organizations.</li> </ul>	[79]

Category	Tool	Purpose	Comments	Ref.
Specific tools	<i>Youth Friendly Services for Married Youth: A Curriculum for trainers. The ACQUIRE Project.</i> (Engender Health, 2008)	<ul style="list-style-type: none"> <li>▪ Enhances understanding of married adolescents' reproductive health needs.</li> <li>▪ Information on appropriate support and services.</li> <li>▪ Involving community members to build a supportive environment.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at health care providers.</li> </ul>	[80]
	<i>Community Involvement Resources.</i> (FHI, 2006)	<ul style="list-style-type: none"> <li>▪ Learning from and with youth and adults within their communities.</li> <li>▪ 4 documents: guidance for participatory assessments; an annotated guide to technical resources; a report of a technical consultation on community involvement; and literature review.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at health and non-health professionals.</li> <li>▪ Resources can be adapted to suit different needs and objectives.</li> </ul>	[81]
	<i>Youth Participation Guide: Assessment, Planning &amp; Implementation.</i> (FHI, 2008)	<ul style="list-style-type: none"> <li>▪ Increasing youth participation in programming.</li> <li>▪ Contains: conceptual overview on youth participation; institutional assessment/planning; youth-adult partnership training curriculum; handouts.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aimed at senior and middle management, program managers, staff and youth implementing activities.</li> </ul>	[82]

## 6. CONCLUSION

As a global professional organisation with extensive country level presence and a high degree of technical competence, FIGO can play an important role in working to improve adolescent sexual and reproductive health around the world. Indeed, this is what FIGO's members would like it to do. Careful consideration, however, needs to be given to where FIGO as an organisation can add greatest value to current activities in ASRH. This is through building on its existing institutional strengths and proven expertise, particularly within the spheres of pre- and in-service training and development of clinical standards and guidelines.

A number of training tools already exist and evidence shows that they are effective. As a result there is no need to duplicate effort by developing new tools. FIGO and its country members are, however, well-positioned to play an active part in adapting these existing tools to ensure that they are appropriate for specific regions, and in implementing, evaluating and monitoring training and capacity-building among obstetricians and gynaecologists. There is also an urgent requirement for other health practitioners, who are often the first point of contact for adolescents when seeking health care and advice, to benefit from FIGO's activities in ASRH. FIGO could optimise the effectiveness of its involvement in these issues and activities by development/membership of coalitions, partnering organisations with existing expertise in programme implementation and management; and participating in multi-disciplinary/multi-sectoral working groups.

There are also areas in which FIGO currently has less experience but potentially could make important contributions to national, regional and global efforts by filling what are often significant gaps at national level. These gaps include:

- ❖ **Situation analysis** – FIGO could contribute to a country-wide or more localised situation analysis depending on existing information. Useful sources of data include Demographic and Health Surveys (DHS), Multi-Indicator Cluster Surveys (MICS), Data sheets from UN agencies, health facility reports and surveys, school surveys, reports from relevant organisations, etc. This is an essential first step to establish the facts on adolescent knowledge, attitudes and behaviour; generate awareness; identify important stakeholders; detect gaps; and, consequently, construct a firm evidence base from which to develop appropriate strategies.
- ❖ **Advocacy** – where a country lacks the legislative basis or effective enforcement of appropriate supportive actions that enhance adolescent well-being, FIGO could play a key role in advocating for improved implementation. Strategic topics include early

marriage, abortion, female genital mutilation, trafficking, and migration, among others.

- ❖ **Policy development** – FIGO could very effectively contribute to the policy discussion as a highly respected international organisation adding formal support to national associations efforts. In countries with existing policy frameworks for adolescents, FIGO members could analyse these for inclusion of the key elements identified in this review. In countries where no such framework is yet in place, FIGO could work with partners to develop a specific policy on ASRH.
- ❖ **Technical guidance in design of specific ASRH initiatives** – on a more practical level, FIGO members could join networks of agencies already active in the field of ASRH and help to design, strengthen, or scale up ASRH interventions.
- ❖ **Quality assurance** – an important aspect of scaling up is to ensure quality in expansion efforts. FIGO could be a useful partner in contributing to quality control of interventions carried out by field organisations and developing mechanisms to ensure adherence to quality standards when extending and adapting programmes.
- ❖ **Monitoring of effectiveness** – this is a critical aspect of programmes and FIGO could extend its professional competence to monitoring and evaluation efforts in order to ensure that ASRH programmes are moving in the right direction and achieving results. As a professional organisation with a strong scientific background, FIGO's endorsement would lend weight to research and publications.
- ❖ **Scaling up** – programmes often flounder when countries try to take successful initiatives to scale unless vital processes are established at an early stage. FIGO could support these efforts through its extensive connections and reputation. Potentially important contributions include mobilising resources, generating awareness with key partners, and involving the private sector.

## **REFERENCES – LITERATURE REVIEW**

### **1. Framework for Action on Adolescents & Youth: Opening Doors with Young people, 4 keys.** UNFPA 2007

<http://www.unfpa.org/public/publications/pid/396>

UNFPA's Framework for Action on Adolescents and Youth articulates a corporate strategy for working with Governments and partners in promoting the comprehensive development of young people worldwide. At a time when the global community is increasingly focused on poverty reduction and broader national development goals, the Framework outlines UNFPA's policy and programme priorities on young people and its contributions with others to the development agenda.

### **2. Youth's Reproductive Health: Key to Achieving the Millennium Development Goals at the Country level.** Advocates for Youth 2005

<http://www.advocatesforyouth.org/publications/iag/millenniumgoalscountry.htm>

In the year 2000, the leaders of 189 countries came together at the Millennium Summit and pledged to: eliminate poverty; create a climate for sustainable development; and ensure human rights, peace, and security for the entire world's people. Eight overarching Millennium Development Goals (MDGs) measure progress towards this vision. None of the MDGs explicitly references youth's reproductive health, even though its relationship to alleviating poverty cannot be overlooked.

### **3. The Sexual & Reproductive Health of Youth: A Global snapshot.** Advocates for Youth 2003

<http://www.advocatesforyouth.org/publications/factsheet/fsglobal.htm>

Worldwide, many youth have had sexual intercourse and are at risk of sexually transmitted infections (STIs), including HIV, or of involvement in unintended pregnancy. Research based reproductive health programmes can provide youth with the information, support, and services they need to make responsible decisions about their sexual health.

### **4. Youth Reproductive and Sexual Health: DHS Comparative reports 19.** USAID 2008

<http://www.measuredhs.com/pubs/pdf/CR19/CR19.pdf>

The study provides information on key reproductive and sexual health indicators in young women and men age 15-24 in 38 developing countries. The data come from Demographic and Health Surveys (DHS) and AIDS Indicator Surveys (AIS) conducted between 2001 and 2005. Indicators are selected for the following key areas: background characteristics; adolescent pregnancy; contraception; sexual activity; and HIV/AIDS-related knowledge, attitudes, and behaviours. Additional analysis examines the association of various individual and household characteristics with the key indicators.

**5. Risk and protective factors affecting adolescent reproductive health in developing countries.** Robert Bloom, WHO 2004

[http://www.who.int/child\\_adolescent\\_health/documents/9241592273/en/index.html](http://www.who.int/child_adolescent_health/documents/9241592273/en/index.html)

In order to determine which risk and protective factors are important for adolescent sexual and reproductive health behaviours, the Department of Child and Adolescent Health and Development (CAH) commissioned a comprehensive review of the literature. Knowing what these factors are, and how they operate, will not only help to target those youth who are at greatest risk for negative health outcomes, but will also help to design more effective programmes.

**6. Adolescent and Youth Sexual and Reproductive Health: Charting Directions for a Second generation of Programming.** UNFPA, Population Council 2002

<http://www.popcouncil.org/pdfs/adolsrh.pdf>

This report summarizes the presentations and discussions of a workshop held to review research and programmes in the area of adolescent reproductive health and development (the “first generation”) and to think critically about key lessons learned from this work as we move forward into the “second generation” of work with this important population. For the purposes of this executive summary, the key points were gathered into two clusters: those that underscore principles of programme planning, design, and evaluation, and those that highlight neglected subjects or subgroups on the adolescent agenda.

**7. Assessing Youth needs and Identifying Programme Opportunities.** YouthNet Brief No. 9. Family Health International 2005

<http://www.fhi.org/NR/rdonlyres/efjtkxorpqyi6rhmyfcmf6keuijygd2l23e6mw66n7epulyu3ciw wfecmmenzu5agci23y3km5kup4o/YNbrief9enyn.pdf>

YouthNet's formal assessments in seven countries identified common themes needing attention including gender and contextual factors, sex education, fragmented services, and medical barriers.

**8. Generation of Change: Young People & Culture. Youth Supplement: State of the World Population 2008.** UNFPA

<http://www.unfpa.org/public/publications/pid/1383>

This Youth Supplement to UNFPA's State of the World Population 2008 focuses on the interactions among culture, gender and human rights and the critical importance of culturally sensitive approaches for effective development policies and programmes. The report, which is the third in a series, addresses culture as it shapes and nurtures the lives of young people and shows how young people develop their own subcultures, which are often different from and may conflict with the dominant culture. The youth report points out the value to young people of protecting the culture in which they grew up, but it also speaks on behalf of their right to embrace their own cultures in their own ways.

**9. Adolescent Sexual Health in Europe and the U.S. - Why the Difference?** Advocates for Youth 2008

<http://www.advocatesforyouth.org/publications/factsheet/fsest.htm>

Regularly since 1998, Advocates for Youth has sponsored study tours to France, Germany, and the Netherlands to explore why adolescent sexual health outcomes are more positive in these European countries than in the United States.

#### **10. Broadening the Horizon: Balancing Protection and Risk for Adolescents. WHO 2001**

[http://www.who.int/child\\_adolescent\\_health/documents/fch\\_cah\\_01\\_20/en/index.html](http://www.who.int/child_adolescent_health/documents/fch_cah_01_20/en/index.html)

Research data from more than 50 countries confirm that there exist strong protective factors against health compromising behaviours in adolescents. This knowledge will help us to balance the traditional focus on risk factors and support the development of interventions that strengthen protective factors in adolescents themselves, in their relations with adults and their wider environment.

#### **11. Creating Youth-Friendly Sexual Health Services in Sub-Saharan Africa. Advocates for Youth 2002**

<http://www.advocatesforyouth.org/publications/iag/youthfriendly.htm>

In most countries in sub-Saharan Africa, youth encounter significant obstacles to receiving sexual and reproductive health services and to obtaining effective, modern contraception and condoms to protect against sexually transmitted infections (STIs), including HIV. Youth-friendly services remove obstacles to sexual health care. Examples of such projects operate in Ghana, Uganda, and Kenya.

#### **12. Adolescent friendly Health services. WHO 2002**

[http://www.who.int/child\\_adolescent\\_health/documents/fch\\_cah\\_02\\_14/en/index.html](http://www.who.int/child_adolescent_health/documents/fch_cah_02_14/en/index.html)

This document is intended for policy makers and programme managers in both developed and developing countries, as well as decision makers in international organizations supporting public health initiatives in developing countries. It makes a compelling case for concerted action to improve the quality - and especially the friendliness - of health services to adolescents. Drawing upon case studies from around the world, it reiterates that this can be - and has been done - by non-governmental organisations and government bodies working with limited financial resources. It highlights the critical role that adolescents themselves can play, in conjunction with committed adults, to contribute to their own health and well being.

#### **13. Special Youth Programme – Report 2007. UNFPA 2008**

<http://www.unfpa.org/public/publications/pid/1184>

This report aims to create awareness among policy and decision makers, programmers and the general public on UNFPA's Special Youth Programme, a global youth-adult partnership initiative that recruits young people from developing countries to join the Fund for a nine-month remunerated fellowship. The assignment includes work both in its Headquarters in New York and its Country Offices around the world, with the purpose of building young people's capacities in the areas of UNFPA's mandate.

**14. Growing in Confidence: Lessons from eight countries in successful scaling up of adolescent health and development programming.** WHO 2002

[http://www.who.int/child\\_adolescent\\_health/documents/fch\\_cah\\_02\\_13/en/index.html](http://www.who.int/child_adolescent_health/documents/fch_cah_02_13/en/index.html)

Programming for adolescent health and development is evolving from attention to issues and projects to more comprehensive national programming approaches. The stories of eight countries provide insight in the road that some countries are taking in trying to go to scale with programmes sometimes at national level. It discusses some important lessons learned that are illustrated by these experiences.

**15. Key issues in the implementation of programmes for adolescent sexual and reproductive health.** Catherine Bond, WHO 2004

[http://www.who.int/child\\_adolescent\\_health/documents/fch\\_cah\\_04\\_3/en/index.html](http://www.who.int/child_adolescent_health/documents/fch_cah_04_3/en/index.html)

This paper provides an overview of implementation issues in ASRH programming, and raises a number of the key questions and issues which need to be addressed. The review has been based upon the published literature and upon programme reports, curricula and articles on the implementation of ASRH programmes produced since 1996. Insights have also been drawn from discussions with programme managers.

**16. Building a Better Future for Youth: Learning from Experience and Evidence. Africa Regional Forum on Youth Reproductive Health and HIV.** WHO, Population Council, Family Health International 2006

<http://www.fhi.org/NR/rdonlyres/eho36sgfeorrmldfkieetyutpqfsg3jefrfosnba6pukqyjabrjcnv65lrggu6fmhmdrq6reqqywjm/tanzaniaythforum.pdf>

YouthNet, working with the World Health Organization and FRONTIERS/Population Council, sponsored an Africa regional forum in June 2006 to share latest research results, programme evidence, and promising interventions for youth; identify gaps in research and programmes; and explore monitoring and evaluation methodologies.

**17. New Findings from Intervention Research: Youth Reproductive Health and HIV Prevention.** Family Health International, Population Council, USAID 2003

<http://www.fhi.org/NR/rdonlyres/eppuglnx7jwaankdtj5vicbvtjfdhdgexbibx4enkjwbwypeux43uzgek3x67gvonf6jic4kogrid/newfindingsmtgreportWeb1.pdf>

This report summarizes meetings held on September 9 and 10, 2003, sponsored by the Population Council's FRONTIERS and Horizons Programmes and YouthNet/Family Health International. Through a series of panel sessions, invited researchers and programme staff presented new findings from youth intervention studies in Bangladesh, Cote d'Ivoire, Kenya, Mexico, Senegal, South Africa, Tanzania, and Thailand. These studies involved school-based interventions or multicomponent interventions to foster reproductive health and HIV prevention. Also available are the PowerPoint presentations, linked through the meeting agenda.

**18. YouthNet End of Programme report: Taking Action: Recommendation and Resources.** Family Health International 2006



<http://www.fhi.org/NR/rdonlyres/ei37kphq4esq2p66wv2mf3vq5esyekaklfn3mcuz4gkj62fakm n3zaw6vgdn5uhdwppauu3xtyaebk/EOPreorteny1.pdf>

The End of Programme report for YouthNet (2001-2006) focuses on the programme's top ten results, with recommendations and resources for taking action.

**19. Intervention Strategies that Work for Youth.** Summary of FOCUS on Young Adults. Youth Issues Paper 1. Family Health International 2002

<http://www.fhi.org/NR/rdonlyres/ecvogmzfwuwx7h2gllaiabwd7yanmgmpvccoijlzwk4amkgsci 2q2ke2323ttc3tna6lxdp32mnhrd/YI1e.pdf>

This paper reports on programmes that have helped young people in developing countries practice healthier behaviours.

**20. Change, Choice & Power: Young Women, Livelihoods and HIV Prevention.** IPPF, UNFPA, Young Positives 2007.

<http://www.unfpa.org/public/publications/pid/401>

The urgency of addressing the vulnerability of young women and adolescent girls of all backgrounds, but particularly the poor, cannot be over stated. Innovative, far-reaching and rapid responses are needed to impact whole generations so that the Millennium Development Goals to reduce poverty can be within reach. This paper sets out to explore the relationship between economic independence, vulnerability to HIV infection, the level of sexual and reproductive health among women and adolescent girls, and gender-based violence.

**21. What about boys? A literature review on the health and development of adolescent boys.** WHO 2000

[http://www.who.int/child\\_adolescent\\_health/documents/fch\\_cah\\_00\\_7/en/index.html](http://www.who.int/child_adolescent_health/documents/fch_cah_00_7/en/index.html)

This literature review sheds new light on how adolescent and girls differ in their health and development needs and what implications these differences have for health interventions. The document takes a gender approach and while assessing the gender specific needs of adolescent males, it provides ideas into how to improve the health and development of adolescent boys and girls.

**22. Summaries of projects in developing countries assisting the parents of adolescents.** World Health Organization; USAID; Family Health International; YouthNet, 2007

[http://www.who.int/child\\_adolescent\\_health/documents/9789241595667/en/index.html](http://www.who.int/child_adolescent_health/documents/9789241595667/en/index.html)

CAH, with the assistance of Department of Population and Family Health of Johns Hopkins University, undertook to identify, describe, and analyze current projects in developing countries that assist parents of adolescents in promoting healthy adolescent development and preventing health risks. Ultimately, this effort identified 34 projects around the world, by means of searching computerized databases, reviews of the internet, materials such as newsletters, reports, government documents, bulletins, conference proceedings, and interviews with individuals and organizations in both developed and developing countries working in fields related to adolescent health.

**23. Helping parents in developing countries improve adolescents' health.** FHI, WHO 2007

[http://www.who.int/child\\_adolescent\\_health/documents/9789241595841/en/index.html](http://www.who.int/child_adolescent_health/documents/9789241595841/en/index.html)

This document provides a summary of the review of projects described above and highlights the importance of parents in preventing adolescent health risk behaviours, the ways in which parents influence these behaviours, and their implications for programmes aiming to improve adolescent health. Five roles are described including their contribution to adolescent health and the corresponding evidence base. Also outlined, where available knowledge exists, are its implications for programmes, including activities that can be delivered to parents to enhance each role and examples of projects currently engaged in activities that address that role.

**24. Community Involvement in Youth Reproductive Health and HIV Prevention.** Youth Lens. No. 19. Family Health International 2007

<http://www.fhi.org/NR/rdonlyres/e2cd4rt7srrydxg6wmvjihbhgrsx6nzyr3me5ekf3m3bxa7o5o6qtdsyte4mo6l6gz2pnmvgdo7sj/YL19e.pdf>

Youth projects are increasingly involving community members in designing, shaping, and implementing projects. Research findings are promising, but more programme experience and research are needed to understand the impact such efforts have.

**25. Adolescent Sexual Health and the Dynamics of Oppression: A Call for Cultural Competency.** Advocates for Youth 2003

<http://www.advocatesforyouth.org/publications/iag/oppression.htm>

This paper encourages those who work with youth to understand the impact of prejudice and discrimination on vulnerable adolescents, to assess and address their needs, and to build on their assets.

**26. Investing in the Next Generation – CEDPA's Youth Development Programme.** CEDPA 2007

<http://www.cedpa.org/content/publication/detail/2047>

The Centre for Development and Population Activities (CEDPA) has reached hundreds of thousands of youth to equip them with specific skills, knowledge, and attitudes to be able to exercise informed decision-making regarding their futures.

**27. Highlights of 25 Years of Youth Sexual and Reproductive Health Programming.** PATH 2003

<http://www.path.org/publications/details.php?i=997>

This publication is a "look back" at highlights of some of PATH's work in youth sexual and reproductive health over the last 20+ years, and also a "look forward," outlining its vision for the future.

**28. Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators.** Inter Agency Working Group (IAWG) on the Role of Community involvement in ASRH. December 2007

<http://www.advocatesforyouth.org/publications/iawg.pdf>

This group advocates for a better articulation of community-involvement processes and for more comprehensive measures of outcomes of community-involvement interventions.

**29. Adolescents, social support and help-seeking behaviour.** Gary Barker, WHO 2007

[http://www.who.int/child\\_adolescent\\_health/documents/9789241595711/en/index.html](http://www.who.int/child_adolescent_health/documents/9789241595711/en/index.html)

This paper addresses two crucial issues in the health and development of adolescents - firstly, what sources of social support are available to them in their communities; and secondly, within the possible sources of support available to them, whom do they turn to for support and why. They are crucial issues because who adolescents can turn to, and who they in fact turn when they need help can make a huge difference to their lives. The paper contains the following:

- The findings of a literature review on the health-seeking behaviour of adolescents.
- The results of consultations with 35 adolescent health programmes from around the world.
- Conclusions and recommendations for action.
- A tool that could be used to carry out a rapid assessment of available social supports and help-seeking behaviours of adolescents.

**30. The Truth about Abstinence Only Programmes.** Advocates for Youth 2007

<http://www.advocatesforyouth.org/publications/factsheet/fsabstinenceonly.htm>

Accurate, balanced sex education – including information about contraception and condoms – is a basic human right of youth. Such education helps young people to reduce their risk of potentially negative outcomes, such as unwanted pregnancies and sexually transmitted infections (STIs). Such education can also help youth to enhance the quality of their relationships and to develop decision-making skills that will prove invaluable over life.

**31. The State of the World's Children 2009.** UNICEF

<http://www.unicef.org/sowc09/>

UNICEF's flagship publication addresses maternal mortality, one of the most intractable problems for development work. The difference in pregnancy risk between women in developing countries and their peers in the industrialised world is often termed the greatest health divide in the world.

**32. Giving Girls Today and Tomorrow: breaking the Cycle of Adolescent Pregnancy.** UNFPA 2007

<http://www.unfpa.org/public/publications/pid/395>

This report highlights the issue of adolescent pregnancy among married and unmarried adolescent girls (10-19 year olds), especially those living in poverty. It draws attention to current trends, as well as the social, economic, and health consequences of adolescent pregnancy not only for the girls themselves, but for their families and countries.

**33. Pregnant Adolescents.** Peter McIntyre, WHO 2006

[http://www.who.int/child\\_adolescent\\_health/documents/9241593784/en/index.html](http://www.who.int/child_adolescent_health/documents/9241593784/en/index.html)

This document is designed to draw the attention of policy makers and programme managers to the need to improve care for pregnant adolescents, both inside and outside the health care system. In doing so, they can contribute to the Millennium Development Goals, connect services better with adolescents, and take steps that will improve maternal health for women of all ages.

**34. Adolescent Health: Global Perspectives on the Sexual and Reproductive Health of Adolescents.** Lancet Series 2007

<http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673607603675.pdf?id=9d3ded37aa4dcc76:6970243a:11fae6d92a8:73621235586472053>

Worldwide, societal shifts and behavioural patterns exacerbated by unique developmental vulnerabilities create a confluence of factors that place today's adolescents at heightened risks for poor health outcomes. Country-level data show that continued investment in effective prevention and treatment strategies is essential to protect adolescents' sexual and reproductive health. Whereas strategies must be tailored to the developmental needs of this age group and their social contexts, effective approaches are multifaceted. Although progress has been made since the 1994 International Conference on Population and Development, adolescents continue to be disproportionately burdened by threats to their sexual and reproductive health.

**35. Saving Young Lives: Pathfinder International's Youth-Friendly Post-Abortion Care Project.** Pathfinder International, October 2008

[http://www.pathfind.org/site/DocServer/YFPAC\\_final.pdf?docID=12601](http://www.pathfind.org/site/DocServer/YFPAC_final.pdf?docID=12601)

This is the report of a project that aimed to increase access to post-abortion care services in eight sub-Saharan African countries - Angola, Ethiopia, Ghana, Kenya, Nigeria, Mozambique, Tanzania and Uganda - that are responsive to the needs of adolescents in sub-Saharan Africa.

**36. Sexually transmitted infections among adolescents: The need for adequate health services.** WHO 2005

[http://www.who.int/child\\_adolescent\\_health/documents/9241562889/en/index.html](http://www.who.int/child_adolescent_health/documents/9241562889/en/index.html)

This document presents a review of the literature documenting existing experience with the provision of STI services for adolescents. It indicates that although increasing efforts have been made to improve adolescent sexual and reproductive health, most emphasize the provision of information and counselling and/or family planning. Less common are initiatives which include STI care. Various models of STI service delivery are reviewed including public and private sector clinics; services based in or linked to schools and stand-alone adolescent specific services. It proposes priority actions in research, policy and service delivery options.

**37. Young people and HIV/AIDS. Opportunity in crisis.** UNICEF, UNAIDS, World Health Organization 2002

[http://www.who.int/child\\_adolescent\\_health/documents/a76791/en/index.html](http://www.who.int/child_adolescent_health/documents/a76791/en/index.html)

*Opportunity in Crisis* is a UNICEF, UNAIDS, WHO advocacy publication that makes a compelling case for the need to focus on young people as a central component of national AIDS control programmes. It includes a range of statistics, including detailed tables of national and regional data that clearly show young people are at the centre of the epidemic, and explain why they are particularly vulnerable to HIV/AIDS.

In addition, *Opportunity in Crisis* outlines a ten-step strategy for accelerated action to prevent HIV/AIDS among young people that includes fighting silence and stigma, increasing access to core interventions such as information, skills and services, decreasing young people's vulnerability and ensuring that they have opportunities to participate.

**38. Youth and the Global HIV/AIDS Pandemic. Advocates for Youth 2008**

<http://www.advocatesforyouth.org/publications/factsheet/fsglobalhiv.htm>

More than twenty five years into the HIV/AIDS pandemic, it remains one of the most serious challenges to global public health. Almost a quarter of people living with HIV are under the age of 25.

**39. Married adolescents: no place of safety. WHO, UNFPA 2007**

[http://www.who.int/child\\_adolescent\\_health/documents/9241593776/en/index.html](http://www.who.int/child_adolescent_health/documents/9241593776/en/index.html)

The World Health Organization, the United Nations Population Fund and the Population Council convened a Technical Consultation on married adolescents in Geneva in December 2003 to address the gap in understanding and programming. The meeting looked at key messages from research and best practice from programmes and at ways to draw this significant problem to the attention of policy makers and programme planners. This document is one outcome of that meeting and looks at what we mean by early marriage, and how, although it is declining around the world, 100 million girls will marry before their 18th birthday over the next ten years. As a result of early marriage, many adolescent girls are having unsafe sex within marriage, with an older and sexually experienced man who may be infected with a sexually transmitted infection, or HIV. It notes how, in many countries, the time gap between getting married and having a first baby is declining. It outlines the risks of too early pregnancy and explores the reasons why families and communities feel under pressure to continue the practice of marrying off their daughters while they are still adolescents.

**40. Will You Listen? Young Voices from Conflict Zones. UNFPA, UNICEF and Women's Commission 2007**

<http://www.unfpa.org/public/publications/pid/410>

The voices of young people from Afghanistan, Angola, Burundi, Colombia, Haiti, Iraq, Liberia, Nepal, the Occupied Palestinian Territory, Rwanda, Somalia, Sudan and many other countries affected by war have been brought together in this unique report. It was compiled from the views and recommendations of some 1700 children and young

people in 92 countries, collected through a series of focus groups and an online questionnaire. The report is a companion to 'Children and Conflict in a Changing World', the 10-year strategic review of the landmark UN report 'The Impact of Armed Conflict on Children', widely known as the Graca Machel study.

**41. Female genital Mutilation: Accelerating Change.** UNFPA, UNICEF 2008

<http://www.unfpa.org/public/publications/pid/1294>

UNFPA and UNICEF are working towards accelerated abandonment of female genital mutilation/ cutting within 17 countries by 2012. The focus of this joint proposal is to leverage social dynamics towards abandonment within selected communities that practice FGM/C. The main strategic approach is to gain the support of an initial core group, which decides to abandon FGM/C and mobilises a sufficient number of people to facilitate a tipping point and thereby create a rapid social shift of the cutting social convention norm. A core feature of implementation is fostering partnerships with government authorities both at decentralised and national levels, religious authorities and local religious leaders, the media, civil society organizations and the education and reproductive health sectors.

**42. Preventing HIV/AIDS in young people: A Systematic review of the evidence from developing countries.** UNAIDS Inter-agency Task Team on Young People 2006

[http://www.who.int/child\\_adolescent\\_health/documents/trs\\_938/en/index.html](http://www.who.int/child_adolescent_health/documents/trs_938/en/index.html)

This report provides evidence-based recommendations for policy-makers, programme managers and researchers to guide efforts towards meeting the UN goals on HIV/AIDS and young people. These goals aim to decrease prevalence and vulnerability; and to increase access to information, skills and services. It also provides a systematic review of the effectiveness of interventions provided: through schools, health services, mass media, communities, and to young people who are most vulnerable to HIV infection.

The report classifies these interventions into three categories:

1. *Steady* (don't implement yet, needs more work and evaluation)
2. *Ready* (implement widely, but evaluate carefully)
3. *Go* (implement on a large scale while monitoring coverage and quality).

**43. School-Based Reproductive Health and HIV Education Programmes – an Effective Intervention.** Youth Lens. No. 21. Family Health International 2007

<http://www.fhi.org/NR/rdonlyres/etnjqxgdtpofo4ouuap5uboxl6pi4jbvd3xuiv2jillybzuok3w3cxbkctiky2jgz7ls423o2ja/YL20e1.pdf>

A review of evaluated programmes shows that well-designed programmes work, but implementation issues such as teacher training and cultural sensitivities remain challenging.

**44. Reaching Out of School Youth with Reproductive Health and HIV/AIDS Information and Services.** Youth Issues Paper 4. Family Health International 2004

<http://www.fhi.org/NR/rdonlyres/egkwwx7wo3ry3o5vwgn6bhxsxcbir5fxzr2f23ke7r2dmnts2koqs6isgvbsydjlyuh5i33gmunfbh/YI4final.pdf>



This paper explores different populations of out-of-school youth, examines the link between schooling and safer sexual behaviours, and presents programmes that work with young people who do not or cannot attend formal schools. Four case studies detailing programmes working with mainstream and marginalized youth are also included.

**45. HIV Prevention for Young people in Developing Countries: Report of a Technical Meeting.** USAID, Institute for Youth development, Family Health International 2003

<http://www.fhi.org/NR/rdonlyres/eslpsquoofurflcvuzwoj5pvlh35geo5csq3fooovtf7svtI5ar6y3i06rbh74jt2ctiortjeqegg/HIVprevenmtgreportWeb.pdf>

This report summarizes a meeting held on July 24, 2003, sponsored by the USAID Office of HIV/AIDS, the Institute for Youth Development, and YouthNet/Family Health International. At the meeting, experts discussed patterns of HIV prevalence and risky behaviours among youth, questioned what we know about preventing risky behaviour among youth, shared strategies for HIV prevention among young people, and described case studies in reducing HIV prevalence. Also available are the PowerPoint presentations, linked through the meeting agenda.

**46. HIV Prevention for Girls and Young Women: Report cards.** IPPF, UNFPA, Global Coalition on Women and AIDS, Young Positives. 2008

<http://www.unfpa.org/public/publications/pid/1201>

A series of national Report Cards on HIV prevention for girls and young women report on progress toward achieving global policy commitments, particularly those outlined in the Political Declaration on HIV/AIDS from the 2 June 2006 High-Level Meeting, to follow up on the United Nations General Assembly Special Session on AIDS. The Report Cards summarize the current situation of HIV prevention strategies and services for girls and young women ages 15-24 years in various countries. They also provide recommendations for key stakeholders to enhance action on HIV prevention strategies and services for girls and young women.

**47. Achieving the Global Goals: Access to Services.** WHO, Family Health International 2003

<http://www.fhi.org/NR/rdonlyres/eswa7gbm7mjiuzf3tk3ymdqzs4qlcugglxlw3autfss2ublsyzomkxnfabh2hijzh5xthfk6fautee/Accessstoservices.pdf>

This report of a technical consultation sponsored by the World Health Organization in collaboration with YouthNet and other UN agencies summarizes the collective views of international experts of a wide range of topics. YouthNet contributions cover youth participation and social franchising.

**48. An Assessment of Services for Adolescents in Prevention of Mother-to-Child Transmission Programmes.** Family Health International 2006

<http://www.fhi.org/NR/rdonlyres/ems26h3jhbqzylerhpbisbo66ur2o56pigowe65f7tfulvkhggdwkvyn5f3ucg3d5tbbzlmosi5axcp/YouthPMTCTeny.pdf>

This report describes the study results conducted at four antenatal care clinics with PMTCT programmes in Kenya. The study identified and evaluated strategies for meeting youth's HIV and reproductive health needs within PMTCT services, based on assessments of HIV/AIDS, PMTCT, and contraceptive related knowledge, awareness, and attitudes that influenced service use

**49. Global Consultation on the health services response to the prevention and care of HIV/AIDS among young people.** WHO 2004

[http://www.who.int/child\\_adolescent\\_health/documents/9241591323/en/index.html](http://www.who.int/child_adolescent_health/documents/9241591323/en/index.html)

This document is intended for individuals and organizations in developed and developing countries that are interested in the prevention and care of HIV among young people. It contains a technical report on a global consultation that examined the health service response to HIV among young people. The report reviews the evidence of effective delivery of successful interventions in a range of settings and develops a set of recommendations as to how to accelerate action towards internationally recognised global goals on HIV and young people in countries.

**50. Protecting the Next generation in Sub-Saharan Africa: Learning from Adolescents to Prevent HIV and Unintended Pregnancy.** Guttmacher Institute 2007

[http://www.guttmacher.org/pubs/summaries/2007/12/12/PNG\\_Summary\\_en.pdf](http://www.guttmacher.org/pubs/summaries/2007/12/12/PNG_Summary_en.pdf)

This report presents key findings from nationally representative surveys conducted in

2004 among 12–19-year-olds in four African countries—Burkina Faso, Ghana, Malawi and Uganda—with the goal of guiding programmes, policies and investments aimed at improving adolescent sexual and reproductive health.

**51. Impact of Sex and HIV Education programmes on Sexual Behaviours of Youth in Developing and Developed Countries.** Family Health International 2005

<http://www.fhi.org/NR/rdonlyres/e4a15tcjlldpzwacxy7ou23ngowdd2xwiznkarhhnptxto4252pgco54yf4cw7j5acujorebfvpug/sexedworkingpaperfinalenyt.pdf>

This paper discusses findings from a review of 83 evaluations of sex and HIV education programmes. The analysis found substantial positive impact on sexual behaviours in more than two-thirds of the evaluations and identified 17 characteristics of the most effective curricula used in the programmes evaluated. More information on this review is available, including links to [data sheets](#) on each of the 83 evaluations.

**52. Life Skills Approaches to Improving Youth's Sexual and Reproductive Health.** Advocates for Youth 2002

<http://www.advocatesforyouth.org/publications/iag/lifeskills.htm>

Research demonstrates that possessing life skills may be critical to young people's ability to positively adapt to and deal with the demands and challenges of life. Some programmes effectively teach and promote life skills. This paper briefly reviews some of these programmes and presents lessons learned from the life skills approach to HIV prevention education. These lessons are also applicable to a wide range of sexual and reproductive health programmes for youth.

**53. The Impact of Life Skills Education on Adolescent Sexual Risk Behaviours.** Population Council, Horizons 2003

<http://www.popcouncil.org/pdfs/horizons/lfskllssum.pdf>



This summary considers the impact of the life skills programme on a population-based sample of youth in two districts in the province of KwaZulu Natal in South Africa.

**54. Global Guidance briefs on HIV interventions for young people.** ILO, UNAIDS Secretariat, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, the World Bank, WFP, WHO 2008

[http://www.who.int/child\\_adolescent\\_health/documents/iatt\\_hivandyoungpeople/en/index.html](http://www.who.int/child_adolescent_health/documents/iatt_hivandyoungpeople/en/index.html)

A series of seven Guidance Briefs has been developed by the Inter-Agency Task Team (IATT) on HIV and Young People. Membership of the IATT includes UNAIDS, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, ILO, WFP, WHO, and the World Bank, along with a growing number of youth networks/associations, donors, civil society, and research institutions. The Briefs comprise one Brief that provides a global overview and is complemented by a separate Brief for most-at-risk young people and five others on HIV interventions among young people provided through different settings/sectors — community, education, health, humanitarian emergencies and the workplace. Each Brief has suggested actions to take at country level and additional resource materials listed.

**55. Participatory Learning and Action: A Powerful Approach with Youth.** YouthNet Brief No. 8. Family Health International 2005

[http://www.fhi.org/NR/rdonlyres/exsf2vxe6xezyrchsol53fwp7kzx27mvc3rmqhtcfg7jlq6nabhw\\_nbnfakshqnvazgpbn56k6vcngg/YNbrief8enyn.pdf](http://www.fhi.org/NR/rdonlyres/exsf2vxe6xezyrchsol53fwp7kzx27mvc3rmqhtcfg7jlq6nabhw_nbnfakshqnvazgpbn56k6vcngg/YNbrief8enyn.pdf)

Participatory approaches led by youth can enhance youth and community involvement, as shown through YouthNet projects in Ethiopia, Namibia, and Tanzania.

**56. More positive living: strengthening the health sector response to young people with HIV.** WHO 2008

[http://www.who.int/child\\_adolescent\\_health/documents/9789241597098/en/index.html](http://www.who.int/child_adolescent_health/documents/9789241597098/en/index.html)

This document is based on the outcome of a WHO/UNICEF consultation that brought together service providers, programmers and young people living with HIV to highlight the special needs of young people living with HIV, and to develop consensus about priority activities for the health sector to meet these needs. The publication is intended for a wide audience, including policy makers and programme staff, and provides an overview of the challenges confronting young people living with HIV and clear recommendations for ways to improve treatment, care, support and prevention services for them.

**57. Protecting young people from HIV and AIDS: The role of health services.** WHO 2004

[http://www.who.int/child\\_adolescent\\_health/documents/9241592478/en/index.html](http://www.who.int/child_adolescent_health/documents/9241592478/en/index.html)

This publication provides an overview of the evidence on health service interventions that are important for achieving the global goals on young people and HIV/AIDS: information and counselling; reducing risk through condoms and harm reduction; and the diagnosis, treatment and care of STIs and HIV/AIDS. In addition, it describes key strategies for delivering these interventions, outlines the quality characteristics of

effective health services for young people, and identifies issues that will need to be taken into consideration when developing national targets for measuring progress towards achieving the goals.

**58. Scaling up Youth Reproductive Health and HIV Prevention Programmes.** Youth Lens. No. 22. Family health International 2007

<http://www.fhi.org/NR/rdonlyres/ehkdgsyalkorpr7ukkwyeu5rdonwdol5ahclbc5dujs4kcieitvqhcv56lxss745xf4sqnsdgd4mqp/YL22e.pdf>

This brief summarizes the latest conceptual thinking and the successful scaling up approaches of large youth projects. It identifies challenging pragmatic issues as well as key actions needed for effective scale-up of youth projects.

**59. Sharing Experiences with Comprehensive responses to Adolescent Reproductive Health needs in Africa.** Population Council (FRONTIERS), USAID March 2008

[http://www.popcouncil.org/pdfs/frontiers/FR\\_FinalReports/Afr\\_YouthScaleup.pdf](http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Afr_YouthScaleup.pdf)

This project seeks to promote the utilization of multisectoral approaches for improving adolescent reproductive health programming by governments, donors, and national and international agencies in francophone West Africa

**60. Integrating Reproductive Health and HIV Services for Youth.** Youth Lens. No. 21. Family health International 2007

<http://www.fhi.org/NR/rdonlyres/efend75c6z55rx3xjxokclmbmk67g4pdxotrtgvi6zdvfdnh32eag27gwgqt7cx5a2vqitsrz554tm/YL21e.pdf>

Research identifies the need for more attention to pregnancy prevention in a variety of settings, but delivery models need further testing.

**61. Addressing the Needs of Young Adolescents.** Youth Lens. No. 27. Family health International 2008

<http://www.fhi.org/NR/rdonlyres/ep26i2zjkcuyuj7oirsix73gkqmmztjw774fuvvg3h2rrfq32lmgmbvkzop7z7ffhodgwbuzhqr3o/YL27e1.pdf>

Although programmes are beginning to pay attention to the needs of young adolescents, more evaluations of these efforts are needed. New interventions are generally either community-based efforts or school-based approaches, including new sexuality and life skills education.

## **REFERENCES - TOOLS / GUIDELINES / TRAINING MATERIALS**

### **62. Orientation programme on adolescent health for health-care providers.** World Health Organization; Commonwealth Medical Association Trust and UNICEF 2006

[http://www.who.int/child\\_adolescent\\_health/documents/9241591269/en/index.html](http://www.who.int/child_adolescent_health/documents/9241591269/en/index.html)

A range of individuals and institutions have important roles in promoting healthy development in adolescents, and in preventing and responding to health problems challenging this population group. Health-care providers (HCP) have important contributions to make in both these areas, however, they are not always well equipped to do this. To bridge this gap, the Department of Child and Adolescent Health and Development (CAH) of the World Health Organization (WHO) is developing the Orientation Programme on Adolescent Health for Health-care Providers (OP) with other partners. The OP is a joint effort of the Commonwealth Medical Association Trust, UNICEF and WHO.

The programme consists of the following:

*Core modules:*

- A. Introduction
- B. Meaning of adolescence and its implications for public health
- C. Adolescent sexual and reproductive health
- D. Adolescent-friendly health services
- E. Adolescent development \*
- F. Concluding

*Optional modules:*

- G. Sexually transmitted infections in adolescents
- H. Care of adolescent pregnancy and childbirth
- I. Unsafe abortion in adolescents
- J. Pregnancy prevention in adolescents
- K. Substance use in adolescents
- L. Mental health of adolescents \*
- M. Nutrition in adolescents \*
- N. HIV/AIDS in adolescents
- O. Chronic diseases in adolescents \*
- P. Endemic diseases in adolescents \*
- Q. Injuries and violence in adolescents \*
- X. Young people and injecting drug use

\*in development

The materials consist of a handout for participants and of a facilitator's guide for the overall course (course director guide) and for all the modules. It provides detailed guidance on how to run each module. In addition it contains tips for the trainers, lecturing aids such as overhead slides in electronic form with accompanying talking points and study materials. Facilitator's guide, handouts for participants, the lecturing aids and study materials are all available on a CD ROM. As per May 2007, the Orientation programme is available in English, French and Russian. Upon request copies of the OP are available in electronic form (CD-ROM) or in printed format. For further information please contact: Department of Child and Adolescent Health and Development, World Health Organization, 1211 Geneva 27, Switzerland, email: [cah@who.int](mailto:cah@who.int)

**63. Guidelines for adaptation of the WHO orientation programme on adolescent health for health care providers in Europe and Central Asia.** WHO, UNFPA, UNICEF 2006

[http://www.who.int/child\\_adolescent\\_health/documents/a91060/en/index.html](http://www.who.int/child_adolescent_health/documents/a91060/en/index.html)

This is a joint document by WHO, UNFPA and UNICEF based on the experiences and reviews of eight countries throughout the European Region. The document provides practical, step-wise guidance in the form of a checklist for planning, organizing, and following up on the national adaptation of the Orientation Programme. It also includes suggestions for strengthening and/or including additional themes in the various modules of the Orientation Programme.

**64. Standards for Curriculum-Based Reproductive Health and HIV Education Programmes.** Family Health International 2006

<http://www.fhi.org/NR/rdonlyres/ea6ev5ygicx2nukyntbvjui35yk55wi5lwnnwkgko3touyp3a33aiczutoyb6zhxcnwiyc37uxyxg/sexedstandards.pdf>

This training material describes 24 standards for use in adapting or developing such curricula in developing countries, grouped in three sections: development and adaptation, content, and implementation. It includes tips on using the standards with examples of how many have been used, and 12 pages of annotated resources.

**65. Faith-based Family Life Education Curricula.** Family Health International 2006

<http://www.fhi.org/en/Youth/YouthNet/Publications/FLE/index.htm>

These curricula include two designed to work with adults with a participant handbook, one for a Christian audience and one for a Muslim one. In addition, a third tool is for working with youth directly, from a Christian perspective. The manuals encourage open discussion about sexuality, reproductive health, and HIV in the context of faith communities. They are not designed to promote religion.

**66. Adolescent Health & development in nursing and midwifery education.** Keeney, Gwen Brumbough; Cassata, Linda; McElmurry, Beverly J.; World Health Organization 2004

[http://www.who.int/child\\_adolescent\\_health/documents/fch\\_cah\\_04\\_4/en/index.html](http://www.who.int/child_adolescent_health/documents/fch_cah_04_4/en/index.html)

This document was developed for professional nursing and midwifery education worldwide and includes strategies for integrating adolescent health and development into curricula and several tools to assist in the integration

**67. Reproductive Health Services for Adolescents. Comprehensive Reproductive Health and Family Planning Training Curriculum 16.** Pathfinder 2002

This module explains the necessity of special training for adolescent reproductive health. It includes sections to sensitize providers to the needs of adolescents and to prepare them to offer reproductive health services so that they are youth-friendly. The module puts particular emphasis on dual protection against STI/HIV and pregnancy, safer sex, counseling, providing care to the pregnant adolescent, and dealing with issues of gender, sexual abuse, and sexual orientation.

- Part 1. Introductory Pages, Participant Handouts (133 pages) (PDF, 608K).

URL: [http://www.pathfind.org/pf/pubs/module16\\_participantsguide\\_part1.pdf](http://www.pathfind.org/pf/pubs/module16_participantsguide_part1.pdf).

- Part 2. Content Units 1-8 (47 pages) (PDF, 479K).

URL: [http://www.pathfind.org/pf/pubs/module16\\_participantsguide\\_part2.pdf](http://www.pathfind.org/pf/pubs/module16_participantsguide_part2.pdf).

- Part 3. Content Units 9-13, Bibliography (42 pages) (PDF, 564K).  
URL: [http://www.pathfind.org/pf/pubs/module16\\_participantsguide\\_part3.pdf](http://www.pathfind.org/pf/pubs/module16_participantsguide_part3.pdf)  
Contact: Mkane@pathfind.org

**68. Youth-Friendly Services: A Manual for Service Providers.** EngenderHealth, 2002

URL: <http://www.engenderhealth.org/res/offc/qi/yfs/index.html>.

This comprehensive curricula addresses provider and site bias toward serving youth, intending to sensitize all staff at a health care facility on the provision of youth-friendly services. All training activities can be adapted and tailored to address the participants' specific needs, depending on their role at the clinic. The training covers such topics as service provider values, adolescent development (psychosocial, physical, and sexual development), sexual and reproductive health issues including contraception and STIs/HIV, and effective communication and counseling skills. It also talks about techniques for creating youth-friendly services called COPE (client-oriented, provider efficient), which enables staff to assess areas for improvement, identify potential solutions, and carry out recommended steps. It includes directions and guidelines for implementing COPE. As shown on the link to the EngenderHealth Web site, the entire curriculum or segments in smaller PDFs can be downloaded: information for the trainer, introductory activities, service provider values, adolescent development, youth sexual and reproductive health, communication with youth, creating youth-friendly services, and closing activities.

Contact: info@engenderhealth.org

**69. Youth-Friendly Pharmacy Program Implementation Kit CD-ROM.** PATH 2004

The comprehensive kit includes the only training curriculum for pharmacy personnel available. It has a particularly strong section on emergency contraception, as well as ongoing contraception methods. Available online in three segments:

- Introduction, Notes to Trainer, Units on Adolescent Reproductive Health, Customer Relations Skills, and Emergency Contraception with job aids and background handouts (103 pages) (PDF, 349K)

URL: [http://www.path.org/files/RH\\_PPIK\\_2.pdf](http://www.path.org/files/RH_PPIK_2.pdf).

- Contraceptive Methods for Ongoing Use (curriculum, job aids, and resource booklet, 48 pages) (PDF, 950K)

URL: [http://www.path.org/files/RH\\_PPIK\\_3.pdf](http://www.path.org/files/RH_PPIK_3.pdf).

- Management of Sexually Transmitted Infections (curriculum, handouts, aids, 43 pages) (PDF, 204K)

URL: [http://www.path.org/files/RH\\_PPIK\\_4.pdf](http://www.path.org/files/RH_PPIK_4.pdf).

Contact: info@path.org

**70. Reproductive Health of Young Adults Training Module.** Family Health International 2003

URL: <http://www.fhi.org/training/en/modules/ADOL/default.htm>.

This Web-based training module is designed to increase the awareness and understanding of the reproductive health needs of young adults among policy-makers, program directors, program planners, and health care providers. The module has four sections: 1) background information, including risks and consequences useful for policy-makers or program directors; 2) information and services young adults need, including how to make services more accessible; 3) clinical information on contraceptive options for youth, especially useful for providers; and 4) issues regarding STI prevention and treatment, including HIV as an urgent issue for youth. The modules can be used either as an interactive self-study program or as a participatory, group

training experience. The self-study program includes an interactive test, which allows a scoring system on knowledge gained through the module. The presenter tools section contains print and projection tools, such as color slides for online presentation, slides for overhead projection, PowerPoint slideshow (95 slides), presenter's notes (72 pages), objectives, handouts, summary fact sheets and evaluation.

Contact: [youthnetpubs@fhi.org](mailto:youthnetpubs@fhi.org)

#### **71. Psychosocial support for children and adolescents. WHO 2005**

[http://www.who.int/child\\_adolescent\\_health/documents/psychosocial\\_support/en/index.html](http://www.who.int/child_adolescent_health/documents/psychosocial_support/en/index.html)

This training module is intended to provide health and mental health personnel with some guidance on a non-disease oriented approach to psychosocial disaster response for children and adolescents. The module provides an overview of the special needs of children and adolescents affected by disasters and emergencies that can help in reaching an understanding of their behaviour after disasters. It addresses the general and specific stressors affecting children and adolescents and examines the consequences of these experiences in helping victims come to terms with their experiences.

#### **72. Counselling skills training in adolescent sexuality and reproductive health: A Facilitator's Guide 2001. WHO**

[http://www.who.int/child\\_adolescent\\_health/documents/adh\\_93\\_3/en/index.html](http://www.who.int/child_adolescent_health/documents/adh_93_3/en/index.html)

A guide to organizing and facilitating a five-day workshop with the purpose of strengthening the knowledge and skills of adults who counsel adolescents. Participants become familiar with the topics of adolescent sexuality and reproductive health. Emphasis is placed on interpersonal communication and listening skills.

The principles of non-directive counselling are introduced. This approach aims to facilitate the young client's overall development by strengthening self-understanding and enhancing their ability to deal personally with present problems and prevent future difficulties.

#### **73. HIV Counselling and Testing for Youth: A Manual for Providers. Family Health International 2007**

<http://www.fhi.org/en/Youth/YouthNet/rhtrainmat/vctmanual.htm>

This HIV counseling and testing manual is designed for service providers and counselors working with youth. Approximately one-third of clients who seek HIV testing are youth, and these young people often have different needs than do adults. With this easy-to-use, spiral bound booklet, service providers and counselors can improve their skills and assist youth with the difficult issue of HIV counseling and testing.



**74. Adolescent Sexual and Reproductive Health: A Training Manual for Programme Managers.** CEDPA 2003

<http://www.cedpa.org/content/publication/detail/662>

As part of the CATALYST Consortium south-to-south programme, PROFAMILIA/Colombia and CEDPA collaborated to produce a manual for managers of adolescent sexual and reproductive health programmes. The manual builds the capacity of youth-serving programme managers and coordinators from the public and private sectors, with limited experience managing youth programmes, to design programmes that respond to the sexual and reproductive health needs and rights of young people (10–24 years of age), and helps youth develop life skills and adopt healthy behaviours. Also available in [Spanish](#).

**75. Toolkit: Get Youth on Board.** GTZ 2008

<http://www.gtz.de/de/dokumente/en-get-youth-on-board-youth-health.2008.pdf>

Effective and sustainable youth health promotion needs an integrated approach that considers the specific situation and problems of young people as well as the socio-cultural environment. This toolkit outlines a number of approaches and gives practical examples.

**76. Hands On: A Manual for working with youth on SRH.** GTZ 2002

<http://www2.gtz.de/dokumente/bib/02-0404.pdf>

This manual lays out useful methods and approaches to support technical co-operation personnel and their partners in the development and implementation of SRH measures with young people in a practical way. It consists of 16 separate yet complementary papers written largely by practitioners from the field. Instead of long theoretical discourses, authors use examples and checklists. All methods and approaches described can be adapted to different settings and various topics. Part one, Methods, consists of a step-by-step guide to a situation analysis, description of methods for baseline data collection, tools for participatory rapid appraisal and indicators for monitoring and evaluation. Part two, Approaches, contains among others checklists for peer education, guidelines for the development of IEC material, theatre plays, or sports activities, and how to support youth organisations and cross-sectoral networking.

**77. Youth-Friendly Services: An Annotated Web-Based Guide to Available Resources.** Family Health International 2004

<http://www.fhi.org/NR/rdonlyres/eg3rssi3iivlljwljutr4mifr3hgzbskpoiwwu46772z6xfnzngf4jhnp3e25kcywwc63t4hhm/YFSGuide3.pdf>

This guide compiles 16 tools useful for programmes seeking to make programmes more youth-friendly. Divided by type of tool (planning, assessment, provider training curricula, etc.), the guide includes easy Web links to the resources.

**78. Youth Peer Education Toolkit.** Family Health International 2006

<http://www.fhi.org/en/Youth/YouthNet/Publications/peeredtoolkit/index.htm>

The Youth Peer Education Toolkit is a group of resources designed to help programme managers and master trainers of peer educators. Collectively, these tools should help develop and maintain more effective peer education programmes. The five parts of the toolkit are based on research and evidence from the field as well as local examples and experiences. They are designed to be adapted locally as needed. The toolkit resulted from collaboration between the United Nations Population Fund (UNFPA) and Family Health International. It was produced for the Youth Peer Education Network (Y-PEER), a project coordinated by UNFPA.

**79. Guide to Implementing TAP (Teens for AIDS Prevention): A Peer Education Programme to prevent HIV and STI.** Advocates for Youth 2002

<http://www.advocatesforyouth.org/publications/tap.htm>

This resource is a step by step guide for programme planners to implementing an HIV/STI prevention peer education programme in your school, faith community, AIDS service organization, and/or community-based organization.

**80. Youth Friendly Services for Married Youth: A Curriculum for trainers.** The ACQUIRE Project, Engender Health 2008

[http://www.acquireproject.org/archive/files/8.0\\_programme\\_for\\_young\\_married\\_clients/8.2\\_resources/8.2.5\\_tools/YoungMarriedTrainers\\_final.pdf](http://www.acquireproject.org/archive/files/8.0_programme_for_young_married_clients/8.2_resources/8.2.5_tools/YoungMarriedTrainers_final.pdf)

This manual seeks to enhance health care providers' understanding of young married men and women's reproductive health needs and enable them to provide appropriate information, support, and services. Moreover, the manual encourages health care providers to reach out to community members and adults and help them create a supportive environment that meets the reproductive health needs of young married couples.

**81. Community Involvement Resources.** Family Health International 2006

<http://www.fhi.org/en/Youth/YouthNet/Publications/CIresources/index.htm>

The community involvement resources consist of four documents produced in partnership with CARE. They offer guidance for conducting participatory assessments, an annotated guide to technical resources, a report of a technical consultation on community involvement, and a literature review. These resources are designed to support those seeking to learn from and with youth and adults within their communities. Users may adapt and adjust the resources to suit their different needs and objectives.

**82. Youth Participation Guide: Assessment, Planning & Implementation.** Family Health International. 2008

<http://www.unfpa.org/public/publications/pid/1325>

Including young people as meaningful partners in programmes that target them with information and services can improve their effectiveness. However, fostering meaningful youth participation remains a challenge. This resource seeks to increase the level of meaningful youth participation in programming at an institutional and programmatic level.

Components include:



- a conceptual overview on youth participation
- an institutional assessment and planning tool
- a youth-adult partnership training curriculum
- background handouts and more

## **Useful Websites**

### **83. UNFPA – publications on adolescents and youth**

[http://www.unfpa.org/public/publications/pubs\\_youth](http://www.unfpa.org/public/publications/pubs_youth)

### **84. Family Health International – publications on youth**

<http://www.fhi.org/en/Youth/YouthNet/Publications/index.htm>

- **Youth Research Working Papers** are in-depth descriptions of research projects undertaken by FHI/YouthNet. They include an introduction, methodology, results, discussion, recommendations, tables, and figures. These papers are part of the overall YouthNet research effort.

<http://www.fhi.org/en/Youth/YouthNet/Publications/YouthResearchWorkingPapers.htm>

- **YouthNet Briefs** is a new series of two-page summaries highlighting YouthNet's global impact by focusing on YouthNet research results, country projects, and technical leadership.

<http://www.fhi.org/en/Youth/YouthNet/Publications/YNbriefs.htm>

To request printed copies of any YouthNet Brief send an email to [youthnetpubs@fhi.org](mailto:youthnetpubs@fhi.org)

- **Youth InfoNet** is a one-stop electronic source for new publications and information on youth reproductive health and HIV prevention, presented in two parts:

**Part I. Programme Resources.** Summaries of tools, curricula, programme reports, unpublished research findings, and other items that may be useful for youth programming. Most items are available online and links to those are included with the summaries

**Part II: Research Articles.** Summaries of peer-reviewed research papers published in the last month on developing country research

<http://www.fhi.org/en/Youth/YouthNet/Publications/YouthInfoNet/index.htm>

- **Youth Lens** is a series of research briefs that summarize the latest information on key issues regarding reproductive health and HIV prevention among youth ages 10 to 24. Beginning with No. 19, YouthLens is published on behalf of the Interagency Youth Working Group, formed in 2006 as part of the USAID Global Leadership Priority on Youth. FHI continues to produce this publication series.

These are available in English, Spanish, and French (Nos. 2-22 and 24-25 in Spanish and French).

<http://www.fhi.org/en/Youth/YouthNet/Publications/YouthLens+English.htm>

- **Youth Issues Papers** are in-depth reviews of critical topics regarding youth reproductive health and HIV/AIDS prevention. They include an analysis of the issue, a literature review, case studies, lessons learned, and ideas about criteria for best practices.

<http://www.fhi.org/en/Youth/YouthNet/Publications/YouthIssuesPapers.htm>

- **FOCUS on Young Adults**, a USAID-supported project that ended in 2001, assisted educational and health service delivery organizations in 30 countries to develop, monitor, and evaluate programmes to improve the reproductive health of young adults. FOCUS was a project of Pathfinder International in partnership with Tulane University School of Public Health & Tropical Medicine and The Futures Group International. The FOCUS on Young Adults project produced hundreds of materials for use by health professionals, educators, community leaders, and parents interested in promoting better health among young people. All publications are available in English; many have been translated in French and Spanish as well.

<http://www.fhi.org/en/Youth/YouthNet/Publications/FOCUS/index.htm>

#### 85. USAID – health policy initiative on youth

<http://www.youth-policy.com//index.cfm?page=index>

This is an online resource for improving youth reproductive health and HIV/AIDS policy worldwide. This site features a searchable database containing 126 full-text policies addressing YRH from 46 countries.

#### 86. WHO Discussion papers on adolescents.

[http://www.who.int/child\\_adolescent\\_health/documents/discussion/en/index.html](http://www.who.int/child_adolescent_health/documents/discussion/en/index.html)

The Department of Child and Adolescent Health and Development (CAH) in collaboration with other WHO departments has initiated a process of reviewing the literature in order to identify existing recommendations on clinical management, and to assess how appropriate these are for adolescents across a wide range of health issues. In the short term, it is expected that this process will lead to the formulation of new recommendations (on clinical management) where none exist or where existing ones are inappropriate. In the medium to long term, the process is also expected to contribute to the improvement of existing WHO guidelines and algorithms (and possibly to the development of new ones, and other “work aids”) to enable health care providers (especially at the primary care level) to meet the special needs of adolescents effectively and with sensitivity.

The review process has now resulted in the production of a number of Discussion Papers (see below) and these have already provided the evidence used to develop WHO guidelines produced by CAH and other WHO departments. Examples include: CAH job aids for health workers working with adolescents; the Contraception Medical Eligibility Criteria; STI guidelines; the Essential Care Practice Guides (integrated management of pregnancy and childbirth (IMPAC), and a guide to decision-making for contraception); the Practical Approach to Lung Health (PAL); and the Integrated Management of Adolescent and Adult Illness (IMAI).

Discussion papers have been developed in the areas of: contraception; pregnancy care; sexually transmitted diseases; unsafe abortion; nutrition; lung health; and malaria. Others are now being developed on HIV/AIDS care; chronic illness; mental health; and substance abuse. Shortened versions have been or will be published in peer-reviewed journals in addition to the completed papers.

**87. Advocates for Youth** – publications on many aspects of adolescent health

<http://www.advocatesforyouth.org/publications/freepubs.htm>

**88. Population Council** – publications

<http://www.popcouncil.org/publications/index.html>

- Studies in Family Planning, December 2008 Special Edition **Focusing on Adolescent Sexual and Reproductive Health in Sub-Saharan Africa**

<http://www.popcouncil.org/publications/sfp/sfpabs/sfpabs394.html>

**89. The Guttmacher Institute** – publications on adolescents

<http://www.guttmacher.org/sections/adolescents.php>

**90. Measure DHS: Demographic and Health Surveys.** Youth Publications

<http://www.measuredhs.com/topics/Youth/publications.cfm>

**91. Popline: The Info Project** – publications on adolescent reproductive health

<http://db.jhuccp.org/ics-wpd/popweb/basic.html>

**92. RHIYA** – EU/UNFPA Reproductive Health Initiative for Youth in Asia

<http://www.asia-initiative.org/index.php>

**93. PATH** – publications on adolescent reproductive health

<http://www.path.org/publications/browse.php?k=18>

## **Terms of Reference for FIGO assignment on Adolescent Sexual and Reproductive Health (ASRH) project**

### **Inputs**

1. Conduct a KAP survey of obs/gyns to determine their attitudes, knowledge and perceptions towards young people's SRH, particularly young women and mothers and within the scope of young people as patients and as a general population. One key question to consider is if obs/gyns in differing regions recognise adolescence as a stage in one's reproductive and sexual health. The survey will also address current clinical practices of obs/gyns, particularly those provided to young people or even if they serve an adolescent clientele.
2. Literature review of studies about young people's attitudes and perceptions of health professionals working in the field of SRH, including existing tools, standards, guidelines, trainings, programs and/or activities which have already been assessed for effectiveness. This will assist in determining the gaps which need to be addressed and avoid duplication of efforts as well as familiarising FIGO with potential partners from which to gain lessons learned.
3. Conduct a review of the existing tools and guidelines for ASRH services which have been already developed by different international organisations and suggest a framework for tools and guidelines to be developed by FIGO.

### **Outputs**

1. Findings report including the above three inputs; the results of the KAP survey, results and bibliographic references from the literature review and the analysis of findings of the existing tools and guidelines for ASRH services.
2. Three separate powerpoint presentations relating to each of the above inputs.
3. Brief progress report to be submitted to FIGO on 12 February 2009, ahead of meeting in Mombasa on 17 February.

### **Timing**

Inputs to begin early January until end of March 2009 with a submission of two introductory letters submitted to FIGO for coordination and circulation to key informants and other stakeholders by the end of December 2008.